

American Family Physician®

A peer reviewed journal of the American Academy of Family Physicians

AFP Clerkship Topic List

Introduction

The American Academy of Family Physicians and its premier clinical journal, *American Family Physician* (AFP), are pleased to offer you this clerkship resource to aid you in your clinical rotations and in preparation for your examinations. AFP has a long history of providing relevant, informative, and up to date evidence-based information for physicians, residents, and medical students. There are also a number of articles that help students learn about the scope of family medicine and about future practice opportunities.

We hope that the articles and resources in this tool will help you as you begin your career in medicine, and we hope that you continue to use *American Family Physician* for many years to come.

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ABDOMINAL PAIN, ACUTE

General

[Left Lower-Quadrant Pain: Guidelines from the American College of Radiology Appropriateness Criteria](#) (10/01/2010)

[Updated Guideline on Diagnosis and Treatment of Intra-Abdominal Infections](#) [Practice Guidelines] (09/15/2010)

[Evaluation of Acute Pelvic Pain in Women](#) (07/15/2010)

[Evaluation of Acute Abdominal Pain in Adults](#) (04/01/2008)

[Opioid Analgesia During Evaluation of Acute Abdominal Pain](#) [Cochrane for Clinicians] (10/01/2007)

[Diagnosis of Acute Abdominal Pain in Older Patients](#) (11/01/2006)

[Acute Abdominal Pain in Children](#) (06/01/2003)

Specific Sites

ABDOMINAL WALL

[The Abdominal Wall: An Overlooked Source of Pain](#) (08/01/2001)

AORTA

[Abdominal Aortic Aneurysm](#) (04/01/2006)

APPENDIX

[ACEP Releases Guidelines on Evaluation of Suspected Acute Appendicitis](#) [Practice Guidelines] (04/15/2010)

[Diagnosis of Appendicitis: Part I. History and Physical Examination](#) [Point-of-Care Guides] (03/15/2008)

[Diagnosis of Appendicitis: Part II. Laboratory and Imaging Tests](#) [Point-of-Care Guides] (04/15/2008)

[Imaging for Suspected Appendicitis](#) (01/01/2005)

ESOPHAGUS

[Diagnosis of Gastroesophageal Reflux Disease](#) [Point-of-Care Guides] (05/15/2010)

[GERD in Adults](#) [Clinical Evidence Handbook] (01/15/2009)

[Esophageal Cancer: A Review and Update](#) (06/15/2006)

[Management of Gastroesophageal Reflux Disease](#) (10/01/2003)

GALLBLADDER

[Management of Gallstones](#) (08/15/2005)

INTESTINES

[Evaluation and Mangement of Intestinal Obstruction](#) (01/15/2011)

[Diverticular Disease: Diagnosis and Treatment](#) (10/01/2005)

[ACG Releases Recommendations on the Management of Irritable Bowel Syndrome](#) [Practice Guidelines] (06/15/2009)

[Treatment of Irritable Bowel Syndrome](#) (12/15/2005)

[Irritable Bowel Syndrome](#) [Clinical Evidence Handbook] (02/01/2005)

[Tegaserod in Patients with Irritable Bowel Syndrome](#) [Cochrane for Clinicians] (12/01/2004)

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ABDOMINAL PAIN, ACUTE

[Tegaserod \(Zelnorm\) for Irritable Bowel Syndrome](#) [STEPS]
(01/15/2004)

KIDNEY/URETER

[Treatment and Prevention of Kidney Stones: An Update](#)
(12/01/2011)

[Medical Management of Common Urinary Calculi](#) (07/01/2006)

PANCREAS

[Chronic Pancreatitis](#) [Clinical Evidence Handbook] (03/01/2008)

[Chronic Pancreatitis](#) (12/01/2007)

[Acute Pancreatitis: Diagnosis, Prognosis, and Treatment](#)
(05/15/2007)

[Pancreatic Cancer: Diagnosis and Management](#) (02/01/2006)

Patient Education, Self-Care

[Preventing Kidney Stones with Diet and Nutrition](#) (12/01/2011)

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AAFP's Patient Education Resource

[Abdominal Pain, Short-Term](#)

[Abdominal Pain, Long-Term](#)

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Attention-Deficit/Hyperactivity Disorder

Overview

[ICSI Releases Guideline on Diagnosis and Management of ADHD in Children](#) [Practice Guidelines] (03/15/2011)

[Current Strategies in the Diagnosis and Treatment of Childhood Attention-Deficit/Hyperactivity Disorder](#) (04/15/2009)

[Adult ADHD: Evaluation and Treatment in Family Medicine](#) (11/01/2000)

Treatment

[Guanfacine \(Intuniv\) for Attention-Deficit/Hyperactivity Disorder \[STEPS\]](#) (02/15/2011)

[Atomoxetine for ADHD](#) [STEPS] (11/01/2003)

[Attention-Deficit/Hyperactivity Disorder](#) [Clinical Evidence Handbook] (05/01/2003)

[AAP Guidelines on Treatment of Children with ADHD](#) [Practice Guidelines] (02/15/2002)

Complications and Special Situations

[AAP Responds to AHA Guidelines on Cardiovascular Monitoring Before Starting Stimulants for ADHD](#) [Practice Guidelines] (05/15/2009)

[AHA Releases Recommendations on Cardiovascular Monitoring and the Use of ADHD Medications in Children with Heart Disease](#) [Practice Guidelines] (05/15/2009)

Editorials and Letters

[Stimulants, ADHD, and the Heart](#) [Editorials] (05/15/2009)

[Multimodal Treatment of Attention-Deficit/Hyperactivity Disorder in Children](#) [Editorials] (04/15/2009)

[ADHD: Management Beyond Medication](#) [Letters to the Editor] (06/15/2002)

[ADHD and IQ Testing](#) [Letters to the Editor] (06/15/2002)

Improving Practice

FROM FAMILY PRACTICE MANAGEMENT

AAFP's Journal of Practice Improvement

[Integrating a Behavioral Health Specialist Into Your Practice](#) (01/01/2011)

Patient Education, Self-Care

[ADHD in Children](#) (04/15/2009)

[What is ADHD?](#) (09/01/2001)

[When Adults Have ADHD](#) (11/01/2000)

FROM FAMILYDOCTOR.ORG

AAFP's Patient Education Resource

[ADHD: What Parents Should Know](#)

[ADHD Medicines](#)

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ALCOHOL ABUSE & DEPENDENCE

Overview

[Helping Patients Who Drink Too Much: An Evidence-Based Guide for Primary Care Physicians](#) (07/01/2009)

[Problem Drinking and Alcoholism: Diagnosis and Treatment](#) (02/01/2002)

[Alcoholism in the Elderly](#) (03/15/2000)

[AAP Statement on Alcohol Use and Abuse](#) [Clinical Briefs] (02/01/2002)

Screening and Diagnosis

[Recognition of Alcohol and Substance Abuse](#) (04/01/2003)

[Problem Drinking and Alcoholism: Diagnosis and Treatment](#) (02/01/2002)

[Alcohol-Related Problems: Recognition and Intervention](#) (01/15/1999)

Treatment

[Opioid Antagonists for the Treatment of Alcohol Dependence](#) [Cochrane for Clinicians] (11/01/2011)

[Effectiveness of Acamprosate in the Treatment of Alcohol Dependence](#) [Cochrane for Clinicians] (03/01/2011)

[Ambulatory Detoxification of Patients with Alcohol Dependence](#) (02/01/2005)

[Management of Alcohol Withdrawal Syndrome](#) [FPIN's Clinical Inquiries] (08/15/2010)

[Effectiveness of Brief Alcohol Interventions in Primary Care](#) [Cochrane for Clinicians] (03/01/2009)

[Alcohol Withdrawal Syndrome](#) (03/15/2004)

[Medications for Treating Alcohol Dependence](#) (11/01/2005)

[Acamprosate \(Campral\) for Treatment of Alcoholism](#) [STEPS] (08/15/2006)

[Management of Withdrawal Syndromes and Relapse Prevention in Drug and Alcohol Dependence](#) (07/01/1998)

[Outpatient Detoxification of the Addicted or Alcoholic Patient](#) (09/15/1999)

[Practical Steps to Smoking Cessation for Recovering Alcoholics](#) (04/15/1998)

Improving Practice

[SAMHSA Substance Abuse Treatment Facility Locator](#)

Patient Education, Self-Care

FROM FAMILYDOCTOR.ORG

AAFP's Patient Education Resource

[Alcohol Abuse: How to Recognize Problem Drinking](#)

[Alcohol: What to Do If It's a Problem for You](#)

[Alcohol Withdrawal Syndrome](#)

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ALCOHOL ABUSE & DEPENDENCE

[Taking Medicines Safely after Alcohol or Drug Abuse Recovery:
Your Doctor Can Help](#)

[Naltrexone for Alcoholism](#)

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ALLERGY and ANAPHYLAXIS

Overview

[Anaphylaxis: Recognition and Management](#) (11/15/2011)

[NIAID Releases Guidelines on Diagnosis and Management of Food Allergy](#) [Practice Guidelines] (06/15/2011)

[Latex Allergy](#) (12/15/2009)

[Food Allergies: Detection and Management](#) (06/15/2008)

[Stinging Insect Allergy](#) (06/15/2003)

[Exercise-Induced Anaphylaxis and Urticaria](#) (10/15/2001)

Screening and Diagnosis

[Urticaria: Evaluation and Treatment](#) (05/01/2011)

[Diagnosing Rhinitis: Allergic vs. Nonallergic](#) (05/01/2006)

Treatment

[Treatment of Allergic Rhinitis](#) (06/15/2010)

[Practice Parameters for Managing Allergic Rhinitis](#) [Practice Guidelines] (07/01/2009)

[AAP Releases Guidelines on Treatment of Anaphylaxis](#) [Practice Guidelines] (10/15/2007)

[The Role of Allergens in Asthma](#) (09/01/2007)

[Leukotriene Inhibitors in the Treatment of Allergy and Asthma](#) (01/01/2007)

[Allergen Immunotherapy](#) (08/15/2004)

[Desloratadine for Allergic Rhinitis](#) [STEPS] (11/15/2003)

[AHRQ Releases Review of Treatments for Allergic and Nonallergic Rhinitis](#) [Practice Guidelines] (12/01/2002)

Patient Education, Self-Care

[Hives: What You Should Know](#) (05/01/2011)

[Latex Allergy](#) (12/15/2009)

[Food Allergies: What You Should Know](#) (06/15/2008)

[Myths and Facts about Food Allergies](#) (12/01/2006)

[Allergy Shots: What You Need to Know](#) (08/15/2004)

[Anaphylaxis](#) (10/01/2003)

[Allergy Testing](#) (08/15/2002)

[Things That Can Cause Asthma and Allergies](#) (08/01/2002)

[Hives and Exercise: What It Means and What to Do](#) (10/15/2001)

Other AFP Content

TIPS FROM OTHER JOURNALS

[Food Introduction and Allergy Development in Infants](#) (10/15/2006)

[Does This Patient Really Have a Penicillin Allergy?](#) (01/01/2002)

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ANEMIA

Overview

SPECIFIC CAUSES

[Update on Vitamin B12 Deficiency](#) (06/15/2011)

[AAP Reports on Diagnosis and Prevention of Iron Deficiency Anemia](#) [Practice Guidelines] (03/01/2011)

[Iron Deficiency Anemia](#) (03/01/2007)

[Alpha and Beta Thalassemia](#) (08/15/2009)

[Clinical Presentations of Parvovirus B19 Infection](#) (02/01/2007)

['Common' Uncommon Anemias](#) (02/15/1999)

SPECIFIC POPULATIONS

[Anemia in Older Persons](#) (09/01/2010)

[Evaluation of Anemia in Children](#) (06/15/2010)

[Prevention of Iron Deficiency in Infants and Toddlers](#) (10/01/2002)

Screening and Diagnosis

[Evaluation of Microcytosis](#) (11/01/2010)

[Screening for Iron Deficiency Anemia, Including Iron Supplementations for Children and Pregnant Women: Recommendation Statement](#) [U.S. Preventive Services Task Force] (08/01/2006)

[Screening for Iron Deficiency Anemia-Including Iron Supplementation for Children and Pregnant Women](#) [Putting Prevention into Practice] (05/15/2009)

[Evaluation of Macrocytosis](#) (02/01/2009)

[Hemolytic Anemia](#) (06/01/2004)

[Normocytic Anemia](#) (11/15/2000)

Treatment

[Transfusion of Blood and Blood Products: Indications and Complications](#) (03/15/2011)

[Ambulatory Management of Common Forms of Anemia](#) (03/15/1999)

Patient Education, Self-Care

[Thalassemia](#) (08/15/2009)

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AAFP's Patient Education Resource

[Anemia \(Normocytic Anemia\)](#)

[Anemia: When Low Iron Is the Cause](#)

[Anemia During Pregnancy](#)

[Iron Deficiency Anemia in Infants and Children: How to Prevent It](#)

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ASTHMA

Overview

[Asthma](#) [Clinical Evidence Handbook] (07/01/2004)

[Asthma and Other Wheezing Disorders in Children](#) [Clinical Evidence Handbook] (12/01/2006)

Screening and Diagnosis

[Evaluation of the Patient with Chronic Cough](#) (10/15/2011)

[Overview of Changes to Asthma Guidelines: Diagnosis and Screening](#) (05/01/2009)

[NAEPP Updates Guidelines for the Diagnosis and Management of Asthma](#) [Practice Guidelines] (07/01/2003)

[The Diagnosis of Wheezing in Children](#) (04/15/2008)

Prevention

[Outdoor Air Pollutants and Patient Health](#) (01/15/2010)

[The Role of Allergens in Asthma](#) (09/01/2007)

Treatment

[Management of Acute Asthma Exacerbations](#) (07/01/2011)

[Medical Therapy for Asthma: Updates from the NAEPP Guidelines](#) (11/15/2010)

[Childhood Asthma: Treatment Update](#) (05/15/2005)

[Are Metered-Dose Inhalers with Holding Chambers Better Than Nebulizers for Treating Acute Asthma?](#) [Cochrane for Clinicians] (01/01/2003)

[Inhaled Steroid Use and Asthma Control in Patients with Mild Persistent Asthma](#) [AFP Journal Club] (07/01/2008)

[Addition of Long-Acting Beta Agonists for Asthma in Children](#) [Cochrane for Clinicians] (03/01/2010)

[Long-Acting Beta2 Agonists as Steroid-Sparing Agents](#) [Cochrane for Clinicians] (06/01/2006)

[Do Children with Acute Asthma Benefit More from Anticholinergics and Beta2 Agonists Than from Beta2 Agonists Alone?](#) [Cochrane for Clinicians] (08/01/2002)

[Should Salmeterol Be Used for Long-Term Asthma Control?](#) [Cochrane for Clinicians] (06/01/2009)

[Levalbuterol Tartrate \(Xopenex HFA\) for the Treatment of Bronchospasm](#) [STEPS] (01/15/2007)

[Leukotriene Inhibitors in the Treatment of Allergy and Asthma](#) (01/01/2007)

[Omalizumab \(Xolair\) for Treatment of Asthma](#) [STEPS] (01/15/2005)

[Developing and Communicating a Long-Term Treatment Plan for Asthma](#) (04/15/2000)

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ASTHMA

Complications and Special Situations

[Exercise-Induced Bronchoconstriction: Diagnosis and Management](#) (08/15/2011)

[Vocal Cord Dysfunction](#) (01/15/2010)

[The 'Crashing Asthmatic'](#) (03/01/2003)

Editorials and Letters

[The New Asthma Guidelines](#) [Editorials] (05/01/2009)

[Beta2 Agonists in the Treatment of Asthma](#) [Editorials] (07/15/2006)

[Exercise-Induced Bronchospasm vs. Exercise-Induced Asthma](#) [Letters to the Editor] (02/15/2004)

Improving Practice

[Improving Adherence to Asthma Therapy: What Physicians Can Do](#) [Editorials] (04/15/2000)

FROM FAMILY PRACTICE MANAGEMENT

AAFP's Journal of Practice Improvement

[Tools and Strategies for Improving Asthma Management](#) (01/01/2010)

[Asthma Days: An Approach to Planned Asthma Care](#) (10/01/2004)

Patient Education, Self-Care

[Exercise-Induced Wheezing](#) (08/15/2011)

[How to Treat an Asthma Attack](#) (07/01/2011)

[Chronic Cough](#) (10/15/2011)

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AAFP's Patient Education Resource

[Asthma Resource Page](#)

Other AAFP Content

TIPS FROM OTHER JOURNALS

[Diagnosing Exercise-Induced Bronchoconstriction](#) (09/15/2010)

[Does Asthma Adversely Affect Pregnancy Outcomes?](#) (04/15/2004)

Other Resources from AAFP

[METRIC. Asthma: Improving Patient Care](#)

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ATRIAL FIBRILLATION

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[Atrial Fibrillation: Diagnosis and Treatment](#) (01/01/2011)

[Updated Guidelines on Management of Atrial Fibrillation from the ACCF/AHA/HRS](#) [Practice Guidelines] (12/01/2011)

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[Outpatient Approach to Palpitations](#) (07/01/2011)

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[Pharmacologic Cardioversion for Atrial Fibrillation and Flutter](#) [Cochrane for Clinicians] (12/01/2005)

[AAFP and ACP Release Practice Guideline on Management of Newly Detected Atrial Fibrillation](#) [Practice Guidelines] (05/15/2004)

[Atrial Fibrillation \(Acute\)](#) [Clinical Evidence Handbook] (05/01/2004)

[Acute Management of Atrial Fibrillation: Part I. Rate and Rhythm Control](#) (07/15/2002)

[Acute Management of Atrial Fibrillation: Part II. Prevention of Thromboembolic Complications](#) (07/15/2002)

CHRONIC

[Rivaroxaban vs. Warfarin for Stroke Prevention in Patients with Nonvalvular Atrial Fibrillation](#) [AFP Journal Club] (03/15/2012)

[Dabigatran \(Pradaxa\) for Prevention of Stroke in Atrial Fibrillation \[STEPS\]](#) (12/15/2011)

[Self-Monitoring and Self-Management of Anticoagulation Therapy](#) [Cochrane for Clinicians] (08/01/2011)

[Catheter Ablation of Supraventricular Arrhythmias and Atrial Fibrillation](#) (11/15/2009)

[Oral Anticoagulants vs. Antiplatelet Therapy](#) [Cochrane for Clinicians] (05/01/2008)

[Atrial Fibrillation \(Chronic\)](#) [Clinical Evidence Handbook] (09/01/2007)

[Choosing Between Warfarin \(Coumadin\) and Aspirin Therapy for Patients with Atrial Fibrillation](#) [Point-of-Care Guides] (06/15/2005)

[Evidence-Based Initiation of Warfarin \(Coumadin\)](#) [Point-of-Care Guides] (02/15/2005)

[Which Patients with Atrial Fibrillation Do Not Need Anticoagulation Therapy with Warfarin?](#) [FPIN's Clinical Inquiries] (09/01/2004)

Improving Practice

FROM FAMILY PRACTICE MANAGEMENT

AAFP's Journal of Practice Improvement

[A Systematic Approach to Managing Warfarin Doses](#)
[Improving Anticoagulation Management at the Point of Care](#)

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ATRIAL FIBRILLATION

Patient Education, Self-Care

[Atrial Fibrillation](#) (01/01/2011)

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AAFP's Patient Education Resource

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Other AFP Content

TIPS FROM OTHER JOURNALS

[Anticoagulation vs. Aspirin Plus Clopidogrel for Atrial Fibrillation](#)
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[Rate vs. Rhythm Control in Atrial Fibrillation](#) (11/01/2005)

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CORONARY HEART DISEASE/CORONARY ARTERY DISEASE

Screening and Diagnosis

[Using Nontraditional Risk Factors in Coronary Heart Disease Risk Assessment](#) [Putting Prevention into Practice] (02/15/2011)

[Using Nontraditional Risk Factors in Coronary Heart Disease Risk Assessment: Recommendation Statement](#) [U.S. Preventive Services Task Force] (02/15/2011)

[Can ECG Rule Out ACS if Performed While the Patient Is Having Chest Pain?](#) [AFP Journal Club] (11/15/2010)

[Global Risk of Coronary Heart Disease: Assessment and Application](#) (08/01/2010)

[AHA Guidelines on Cardiac CT for Assessing Coronary Artery Disease](#) [Practice Guidelines] (03/01/2008)

[Cardiomyopathy: An Overview](#) (05/01/2009)

[Diagnosis of Acute Coronary Syndrome](#) (07/01/2005)

[Noninvasive Cardiac Imaging](#) (04/15/2007)

[Update on Exercise Stress Testing](#) (11/15/2006)

[Radiologic Evaluation of Acute Chest Pain—Suspected Myocardial Ischemia](#) (08/15/2007)

[Contemporary Management of Angina: Part I. Risk Assessment](#) (11/01/1999)

Prevention

[AHA Updates Guidelines on CVD Prevention in Women](#) [Practice Guidelines] (01/01/2012)

[Aspirin for the Prevention of Cardiovascular Disease: Recommendation Statement](#) [U.S. Preventive Services Task Force] (06/15/2011)

[Aspirin for the Prevention of Cardiovascular Disease](#) [Putting Prevention into Practice] (06/15/2011)

[Primary Prevention of CVD: Physical Activity](#) [Clinical Evidence Handbook] (07/15/2010)

[Diets for Cardiovascular Disease Prevention: What Is the Evidence?](#) (04/01/2009)

[Preventing Cardiovascular Disease in Women](#) (10/15/2006)

[Hormone Therapy for the Prevention of Chronic Conditions in Postmenopausal Women](#) [Putting Prevention into Practice] (12/15/2005)

[Hormone Therapy for the Prevention of Chronic Conditions in Postmenopausal Women](#) [U.S. Preventive Services Task Force] (07/15/2005)

[Should We Use Multiple Risk Factor Interventions for the Primary Prevention of Coronary Heart Disease?](#) [Cochrane for Clinicians] (07/15/2002)

Treatment

ACUTE

[Drug-Eluting Coronary Artery Stents](#) (12/01/2009)

[ACC/AHA Guideline Update for the Management of ST-Segment Elevation Myocardial Infarction](#) (06/15/2009)

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CORONARY HEART DISEASE/CORONARY ARTERY DISEASE

[Acute Coronary Syndrome \(Unstable Angina and non-ST Elevation Myocardial Infarction\)](#) [Clinical Evidence Handbook] (08/15/2009)

[Unstable Angina and Non-ST- Segment Elevation Myocardial Infarction: Part I. Initial Evaluation and Management, and Hospital Care](#) (08/01/2004)

[Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction: Part II. Coronary Revascularization, Hospital Discharge, and Post-Hospital Care](#) (08/01/2004)

[Heparins for Unstable Angina and Non-ST-Segment Elevation Myocardial Infarction](#) [Cochrane for Clinicians] (04/01/2009)

[Early Invasive Therapy or Conservative Management for Unstable Angina or NSTEMI?](#) [Cochrane for Clinicians] (01/01/2007)

[Aspirin Combined with Clopidogrel \(Plavix\) Decreases Cardiovascular Events in Patients with Acute Coronary Syndrome](#) [Cochrane for Clinicians] (12/01/2007)

CHRONIC

[Medical Management of Stable Coronary Artery Disease](#) (04/01/2011)

[AHA Releases Guidelines for Hypertension Management in Adults with or at Risk of CAD](#) [Practice Guidelines] (07/15/2008)

[Secondary Prevention of Coronary Artery Disease](#) (02/01/2010)

[Exercise-Based Rehabilitation for Coronary Heart Disease](#) [Cochrane for Clinicians] (08/01/2004)

[Cardiovascular Risk Reduction in Children](#) [Practice Guidelines] (06/15/2007)

[Ranolazine \(Ranexa\) for Chronic Angina](#) [STEPS] (02/15/2007)

[Nutritional Assessment and Counseling for Prevention and Treatment of Cardiovascular Disease](#) (01/15/2006)

[Cardiac Rehabilitation](#) (11/01/2009)

[Prognosis for Patients Undergoing Coronary Angioplasty](#) [Point-of-Care Guides] (11/15/2004)

[Is Prasugrel More Effective Than Clopidogrel in Patients with Acute Coronary Syndrome Scheduled for PCI?](#) [AFP Journal Club] (12/01/2008)

[Contemporary Management of Angina: Part II. Medical Management of Chronic Stable Angina](#) (01/01/2000)

[ACC/AHA Revise Guidelines for Coronary Bypass Surgery](#) [Practice Guidelines] (05/01/2000)

Complications and Special Situations

[Beta Blockers and Noncardiac Surgery: Why the POISE Study Alone Should Not Change Your Practice](#) [AFP Journal Club] (03/15/2010)

[Preparation of the Cardiac Patient for Noncardiac Surgery](#) (03/01/2007)

[Right Ventricular Infarction: Specific Requirements of Management](#) (09/15/1999)

Editorials and Letters

[Appropriate Aspirin Use for Primary Prevention of Cardiovascular Disease](#) [Editorials] (06/15/2011)

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CORONARY HEART DISEASE/CORONARY ARTERY DISEASE

[The Case Against Routine Aspirin Use for Primary Prevention in Low-Risk Adults](#) [Editorials] (06/15/2011)

[Is There Benefit to Coronary Calcium Screening?](#) [Editorials] (04/15/2007)

Other Resources from AAFP

[METRIC. Coronary Artery Disease: Improving Patient Care](#)

Improving Practice

[Overcoming the Challenges Facing Quality Improvement Strategies for Non-ST-Segment Elevation Acute Coronary Syndromes](#) [Editorials] (11/15/2004)

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[Estimating the Risks of Coronary Angioplasty](#) (11/01/2004)

[Weighing the Risks and Benefits of Clinical Interventions](#) (01/01/2004)

Patient Education, Self-Care

[Heart Attack: What Is Your Risk?](#) (08/01/2010)

[Coronary Artery Disease and the Use of Stents](#) (12/01/2009)

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AAFP's Patient Education Resource

[Vascular Disease: How to Prevent Coronary Artery Disease, Heart Attack and Stroke](#)

[Coronary Heart Disease: Reducing Your Risk](#)

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CANCER

General

SCREENING/PREVENTION

[Cancer Screening in the Older Patient](#) (12/15/2008)

[Lifestyle Interventions to Reduce Cancer Risk and Improve Outcomes](#) (06/01/2008)

[Physicians Who Do Not Follow Screening Guidelines](#) [Curbside Consultation] (01/01/2006)

[Screening for Cancer: Evaluating the Evidence](#) (02/01/2001)

TREATMENT/SURVEILLANCE

[Managing the Adverse Effects of Radiation Therapy](#) (08/15/2010)

[Exercise for the Management of Cancer-Related Fatigue](#) [Cochrane for Clinicians] (10/01/2009)

[Targeted Therapies: A New Generation of Cancer Treatments](#) (02/01/2008)

[Primary Care of the Patient with Cancer](#) (04/15/2007)

[Treatment of Oncologic Emergencies](#) (12/01/2006)

[Determining Prognosis for Patients with Terminal Cancer](#) [Point-of-Care Guides] (08/15/2005)

[Care of Cancer Survivors](#) (02/15/2005)

[Neurological Complications of Systemic Cancer](#) (02/15/1999)

Breast Cancer

SCREENING/PREVENTION

[American College of Obstetricians and Gynecologists Updates Breast Cancer Screening Guidelines](#) [Practice Guidelines] (03/15/2012)

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STROLLING *through the* **MATCH**

The future is *yours* to discover.
EXPLORE YOUR OPTIONS TO FIND YOUR MATCH.

2012 - 2013



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STRONG MEDICINE FOR AMERICA

April (Junior Year) – March (Senior Year)

88 (check with your dean's office for specific recommendations)

88 (check with your dean's office for specific recommendations)

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The American Academy of Family Physicians (AAFP) is very pleased to provide you with this copy of *Strolling Through the Match*, a guidebook to residency selection. Additional copies of this product are available upon request by calling 800-944-0000. This guide, along with other student and residency resources, are also available at <http://fmignet.aafp.org/> and www.aafp.org/strolling

Acknowledgments

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INTRODUCTION

We developed *Strolling Through the Match* to help you make appropriate decisions about your professional career and to learn more about the process of getting post-graduate training. This book emphasizes a practical approach and encourages you to gather and summarize specialty information, establish timelines, and organize checklists and reference materials.

This guidebook is not a publication of the National Resident Matching Program (NRMP) or ERAS® the Electronic Residency Application Service, nor was it developed under their auspices. The material is intended to complement the information provided by the NRMP and ERAS to medical students about residency selection.

The format of this guide is designed to let you supplement this information with locally-derived materials. You may want to add to or subtract from its contents to suit your specific needs. We hope these materials will complement and expand upon existing programs on residency selection in various medical schools. The AAFP invites and welcomes your feedback on the usefulness of this guide as it seeks to help the professional development of future physicians.

ERAS®

Special information on the ERAS — Electronic Residency Application Service — is provided throughout this guidebook. If you plan to apply for residency or fellowship training in one of the specialties using ERAS, please carefully read the sections on ERAS.

Not all of the training programs within the ERAS specialties will accept applications via ERAS. You will be required to submit paper applications to programs not participating in ERAS. Contact the programs in which you're interested to find out the method for applying to them.

INTRODUCTION TO ERAS

What is ERAS?

ERAS — the Electronic Residency Application Service — was introduced by the Association of American Medical Colleges in 1995 to automate the residency application process. The service uses the Internet to transmit residency and fellowship applications, letters of recommendation, dean's letters, transcripts,

and other supporting credentials from applicants and medical schools to residency and fellowship program directors.

The Electronic Residency Application Service has three distinct application season cycles during which applicants can apply to residency or fellowship programs:

Residency Cycle	The main residency match opens for applicants on August 15, 2012. Residency specialties begin receiving applications on September 1. The NRMP Main Match occurs on the third Friday in March and residents begin training July 1, 2013.
July Start Cycle	Osteopathic internships and fellowship programs begin receiving applications on July 15, 2012. The osteopathic match is in February 2013; applicants begin training on July 1, 2013. Fellowship specialties participating in this cycle usually have their match in December of the same year they begin receiving applications; fellows begin training July 1 the following year.
December Start Cycle	Sub-specialty fellowship programs begin receiving applications on December 1. Formalized matches, for specialties that have them, generally occur in May or June. Fellows applying to programs in these specialties typically begin training a year later, in July.

Important if you're applying for residency positions in the 2012 – 2013 residency cycle. Specialties participating in this cycle are:

- Adolescent Medicine
- Anesthesiology
- Army & Navy Residency Programs
- Combined Med-Peds
- Dermatology
- Diagnostic Radiology
- Emergency Medicine
- **Emergency Medicine/Family Medicine**
- **Family Medicine**
- Internal Medicine (including IM/Derm, IM/ER, IM/Peds, IM/Med Rehab, IM/Psych, IM/Preventive & IM/Genetics)
- **Internal Medicine/Family Medicine**
- Neurological Surgery
- Neurology/Child Neurology
- Nuclear Medicine
- Obstetrics and Gynecology
- Orthopaedic Surgery
- Otolaryngology
- Pathology
- Pediatrics (including Peds/Derm, Peds/ER, Peds/Med Rehab, Peds/Psych, Peds/Genetics)
- Physical & Rehabilitative Medicine
- Plastic Surgery and Plastic Surgery Integrated
- Preventive Medicine (Public Health, General, Occupational and Aerospace)
- Psychiatry
- **Preventive Medicine/Family Medicine**
- **Psychiatry/Family Medicine**
- Radiation Oncology
- Sleep Medicine
- Surgery
- Transitional Year
- Urology
- Vascular Surgery

New fellowship sub-specialties for the 2012 – 2013 season were:

- Pediatric Endocrinology
- Pediatric Infectious Disease

Eligibility for fellowship positions generally requires completion of a residency program. Contact the fellowship program for specific requirements and instructions for applying.

How Does ERAS Work?

Four components comprise ERAS: the applicant's Web application (MyERAS), the Dean's Office Workstation (DWS), the Program Director's Workstation (PDWS), and the ERAS PostOffice. Applicants must go to the ERAS Web site to complete an application and program designation list and to transmit them to the electronic ERAS PostOffice for processing. The designated dean's office attaches the applicant's transcripts, Medical School Performance Evaluation (MSPE)/dean's letter, and letters of recommendation using the DWS, then transmits the documents to the ERAS PostOffice for the programs designated by the applicant. The program directors download application materials using the PDWS from the ERAS PostOffice.

What are the advantages of using ERAS?

ERAS saves time. With ERAS, you don't have to complete an application and request supporting materials for each program to which you're applying. You complete one application and send it to all programs you've selected.

Also, ERAS is very user friendly. It is very intuitive, and the easy-to-follow instruction manual guides you through the application completion with relative ease.

ERAS offers a great deal of flexibility. You decide how many personal statements and letters of reference you want to use in the application process, and you assign these documents to individual programs. You may want to designate that all programs receive the same documents or you can customize documents for each program.

Who can use ERAS?

- Adolescent Medicine
- Anesthesiology
- Dermatology
- Diagnostic Radiology
- Emergency Medicine
- **Family Medicine**
- Internal Medicine (including preliminary programs)
- Neurology
- Neurological Surgery
- Nuclear Medicine
- Obstetrics and Gynecology
- Orthopaedic Surgery
- Osteopathic Internships (*26 specialties*)
- Otolaryngology
- Pathology (including preliminary programs)
- Pediatrics
- Pediatrics/Psychiatry/Child Psychiatry
- Physical & Rehabilitative Medicine
- Plastic Surgery
- Preventive Medicine
- Psychiatry
- Combined Med-Peds
- Radiation Oncology
- Sleep Medicine
- Surgery
- Transitional Year
- Army and Navy residency programs
- Combined Psychiatry/Neurology
- Vascular Surgery – Integrated

Fellowship specialties using ERAS are:

- Allergy/Immunology
- Cardiovascular Disease
- Colon and Rectal Surgery
- Endocrinology
- Female Pelvic Medicine and Reconstructive Surgery
- Gastroenterology
- Gynecologic Oncology
- Hematology
- Hematology/Oncology
- Infectious Diseases
- Interventional Cardiology
- Maternal – Fetal Medicine
- Medical Genetics
- Nephrology
- Neonatal/Perinatal Medicine
- Oncology
- Pediatric Cardiology
- Pediatric Critical Care Medicine
- Pediatric Emergency Medicine (ER & Peds)
- Pediatric Endocrinology
- Pediatric Gastroenterology
- Pediatric Hematology/Oncology
- Pediatric Infectious Disease
- Pediatric Nephrology
- Pediatric Pulmonology
- Pediatric Rheumatology
- Pediatric Surgery
- Pulmonary Medicine
- Pulmonary/Critical Care
- Rheumatology
- Thoracic Surgery
- Vascular Surgery

(Note that some programs may not participate and may require applicants to complete a paper application. Contact the programs you are interested in to learn about their application procedures.)

MyERAS contains a list of programs you can select to receive your application materials electronically. Because ERAS is not the definitive source of program participation, you should contact the programs in which you're interested before you apply.

Students and graduates of U.S. allopathic and osteopathic medical schools should contact the dean's office at their school of graduation for ERAS information and processing procedures.

International Medical Graduates (IMGs) should contact the Educational Commission for Foreign Medical Graduates (ECFMG) early for instructions about applying to residency programs using ERAS. If you have questions, see **www.ecfm.org/eras** for details. Section 2 of Strolling also has information for IMGs.

Canadian applicants should contact the Canadian Resident Matching Service (CaRMS). Go to **www.carms.ca**. Applicants interested in applying to fellowship programs should go to the EFDO at **www.erasfellowshipdocuments.org** for information.

It is important that you contact the programs directly to determine their participation in ERAS before you apply. You can visit program websites to learn about their requirements and application mechanism (ERAS or paper). Programs accepting applications via ERAS will communicate this to applicants. Although MyERAS displays programs that have indicated they will receive applications through ERAS, some may change their process after the ERAS software has been released, so directly contact the program before applying.

Step 2

U.S. medical students and graduates should contact the dean's office at their schools of graduation to determine when ERAS packets will be available. IMGs and Canadian applicants should contact their designated deans' offices to get procedures for obtaining an ERAS packet. Applicants should get an ERAS packet and begin completing applications as early as possible in the match season.

Step 3

Go to the ERAS website, www.aamc.org/eras, and complete your application and designation list. The on-line help will guide you through the completion of the ERAS application.

Step 4

Take a recent photograph to your designated dean's office for processing.

- Ask all letter of recommendation (LOR) writers to send LORs to your designated dean's office.
- Ensure that all segments of the application have been completed and your designated list of programs is final. ***No programs can be deleted once the application has been transmitted to the ERAS PostOffice.***

Step 5

The Applicant Documents Tracking System (ADTS) uses e-mail to acknowledge documents that are downloaded by programs. Check your e-mail frequently for requests for additional information and invitations.

What are the steps in the ERAS process for fellowship applicants?

Step 1

Contact programs directly to learn about their participation status in ERAS, the ERAS Application Cycle in which they are participating, their program requirements and the mechanism (ERAS or paper) for applying to their programs.

Step 2

Contact the ERAS Fellowships Documents Office (EFDO) for an electronic token, instructions for accessing MyERAS, and information for completing the application process using ERAS.

Step 3

Go to the ERAS website www.aamc.org/eras and complete your application and designation list. Use online help to guide you through the process of completing your ERAS application.

Step 4

Send a recent photograph to the EFDO

- Contact your medical school of graduation and have them send your MSPE/Dean's Letter (if available) and transcript directly to the EFDO.
- Direct all letter of recommendation writers to send letters directly to the EFDO.

Step 5

The Applicant Documents Tracking System (ADTS) uses e-mail to acknowledge documents that are downloaded by programs. Check your e-mail frequently for requests for additional information and or interview invitations.

How does the Dean's Office Workstation (DWS) work?

The designated dean's office (and the EFDO for fellowship applicants) transmits your letters of recommendation, MSPE dean's letter, transcript and photograph to the programs' "mailboxes" at the ERAS PostOffice.

The EFDO and schools determine their own procedures and timelines for processing ERAS materials. Make sure you understand and follow the procedures to ensure your ERAS materials are processed in a timely manner. If you have any questions about the processing of your application, contact your designated dean's office.

How does the Program Director's Workstation (PDWS) work?

The PDWS is organized into electronic file folders by applicant identification number. It designed to allow programs to efficiently download and review residency applications. [Program directors use a variety of ERAS features to review and evaluate the applications].

Where can I find help if I need it?

Your dean's office is always the first step in resolving and troubleshooting problems. Another option is MyERAS, which has an on-line help feature, ASK F1, to help you while you're using the software. It also has an instruction manual that provides a breadth of information. The ERAS website at **<http://www.aamc.org/eras>** has a frequently asked questions (FAQ) section. Applicants also can e-mail **myeras@aamc.org** with questions not answered by the ERAS FAQ. The response time is typically one business day.

Section 1

CHOOSING A SPECIALTY

HOW TO CHOOSE A SPECIALTY

This section provides information about various specialties, factors to consider in choosing a specialty and

- a bibliography of books, web sites and articles
- a tool for getting information about different specialties from clinical departments in your medical school
- a list of the different types of accredited residency training programs
- a list of specialty organizations that can provide more information

You also can view this guide along with other specialty choice resources on the AAFP student website at <http://fmignet.aafp.org/>

Choosing a specialty may be one of the most difficult decisions you will ever make in your medical career. It would be easy if you could somehow transport yourself through time and preview your career as a family physician, surgeon, pediatrician or radiologist. Instead, you and other medical students must decide your specialty based on the limited view you get from clinical rotations. Often, those first clinical experiences are so exciting and interesting you think you'll never decide what is the right fit for you. A particularly exciting clinical experience might convince some to pursue a certain specialty, but most medical students weigh several options after many clinical and non-clinical experiences. Armed with a balanced view of each specialty and an awareness of your strengths and interests, you'll find your way.

Making the decision begins with answers to questions that determine your personal and professional needs:

- What were your original goals when you decided to become a physician? Are they still valid?

- What do you value about the role of a physician? Is it the intellectual challenge, the ability to help others, the respect it commands from others, the security of the lifestyle, the luxury of the lifestyle, the ability to work autonomously? Which aspects do you value the most?
- What type of doctor/patient relationships do you find the most rewarding?
- What type of lifestyle do you envision for yourself (time for family, time for other interests, income level, etc.)?
- In what type of community do you see yourself practicing and in what type of clinical setting?
- What skills (interpersonal, analytical, technical, etc.) do you value the most in yourself and how do they affect your perception of the specialty or specialties to which your abilities are best suited?
- Are there particular clinical situations or types of patient encounters that make you uncomfortable or for which you feel unsuited?

Answering these questions takes a great deal of maturity and insight. But be completely honest with yourself so you will be confident of your choices. You may find it particularly difficult to be frank with yourself about your own abilities. There is a danger of either overestimating or underestimating yourself, so get feedback from people who know you personally and professionally. Mentors are a good touchstone during this phase of the specialty choice process.

As you begin to form some ideas of the career you would like to have, you'll have new questions about specific specialties and their respective training programs. Take time to write down what you already know about each of the specialties in which you're interested. Is the information you have accurate and complete? What else do you need to know?

With Regard to the Practice Characteristics of a Particular Specialty, What Do You Know About...

- the type and degree of patient contact?
- the type of patient treated?
- the type of skills required?
- the type of disease entities and patient problems encountered?
- the variety of practice options available within that specialty?
- the type of research being done in that specialty?
- the type of lifestyle afforded?

With Regard to the Residency Training Programs for a Given Specialty, What Would You Like to Know About ...

- the length of training?
- the goals of training? (What does residency training prepare you to do?)
- the availability of residency positions? (How many slots are available? What is the level of competition for those slots?)
- the differences between training programs within the same specialty? (Are there geographic differences? Are there institutional differences?)
- the potential for further training following a residency? (What are the requirements for subspecialty training or fellowship training?)

With Regard to the Overall Outlook for a Particular Specialty, What Would You Like to Know About ...

- the availability of practice opportunities? (How much competition is there for patients or practice sites?)
- any current trends or recent changes in practice patterns for that specialty? (How has it been affected by the cost of professional liability insurance? By changes in Medicare reimbursement policies or health care reform legislation?)

- any foreseeable additions to the repertoire of that specialty? (New technologies, new drugs or new techniques?)

You already have a great deal of information at your fingertips if you need help answering some of these questions. If your school has a faculty advising system or a career advising office, use it. Don't hesitate to approach faculty and other physicians with whom you have established some rapport.

You also should ask faculty for recommendations and introductions to physicians who have similar interests. Take advantage of opportunities to meet with physicians from various specialties, perhaps at events or meetings sponsored by your school (i.e., career days, hospital fairs). Often, local medical societies or specialty societies have meetings that are open to students. Organizations such as the American Academy of Family Physicians and American Academy of Pediatrics give medical students the opportunity to join as members, for free.

National meetings, such as the AAFP-sponsored National Conference of Family Medicine Residents and Medical Students, are also valuable sources for information about specialty choice, visit www.aafp.org/nc for more information. Attend meetings hosted by student organizations and interest groups at your school. You also can address career issues with the American Medical Association-Medical Student Section (AMA-MSS), American Medical Student Association (AMSA), Family Medicine Interest Groups (FMIG), the Organization of Student Representatives, Association of American Medical Colleges (OSRAAMC), the Student National Medical Association (SNMA), the Latin American Medical Student Association (LMSA) or the Asian Pacific American Medical Student Association (APAMSA).

Using elective time to explore specialty options can be extremely helpful, particularly if you want more exposure to certain specialties. You can choose an elective within your own institution or you can choose an outside elective or clerkship. You can arrange a

clerkships either with private physicians in the community or at another teaching institution. The clerkship can be purely clinical or have a component of research or community outreach. Ask your medical school advisor or student affairs office for information about locally-available clerkship opportunities. Or contact your local medical specialty society, national medical specialty societies, Area Health Education Center or other teaching institutions (medical school departments or residency programs) for information about clerkships. Go to the AAFP student web site at <http://www.aafp.org/clerkships> for a directory of clerkships and electives in family medicine and related clinical areas.

We strongly advise that you begin planning your electives as early as possible. Though your school's curriculum may not permit you to take elective time until your fourth year, careful planning will let you assess your specialty options before you begin the process of residency selection.

The following references and list of organizations may be useful. Several publications regularly feature articles on career selection, trends in specialties, and changes in the types and numbers of residency positions.

Keep in mind that many sources may present biased information. Generally, you can resolve questions and concerns by looking for common themes, then outlining pros and cons. Only you know what is right for you, and no amount of information from a single source should determine your choice. So try to get information from as many different sources as possible: student colleagues, senior medical students, residents, faculty advisors, department chairs, physicians in private practice, relatives, friends and medical organizations.

Avoid making assumptions; develop a broad and well-balanced picture of the specialty you're considering. As with every other major decision in your life, making this decision may come with a certain amount of doubt. But, if you've approached the process with a willingness to look at yourself honestly

and if you've tried to get the best available information, you can trust that your decision will be a good one.

Suggested References

Books

Graduate Medical Education Directory (GMED), American Medical Association, 2011 – 2012 Edition.

Often referred to as the "Green Book." The official list of all residency training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) for all specialties. Includes the accreditation requirements for each type of training program and some statistical information on numbers of residents and residency positions for each specialty. Available in most medical school libraries and also available for purchase online from the AMA online at <https://catalog.ama-assn.org/Catalog>.

Check to see if your Dean's office or Admissions Office has a subscription to the online version.

How to Choose a Medical Specialty, Anita D. Taylor, Philadelphia: W.B. Saunders Co., 4th Edition, 2003.

This is a popular resource on the process of choosing a specialty. It includes overviews of key specialties, data regarding projected supply and demand, the economic outlook for the specialty, as well as information on residency training.

Iserson's Getting into a Residency: A Guide for Medical Student, Kenneth V. Iserson Galen Press, Student Ltd, 6th Edition.

A step-by-step guide through the process of selecting a medical specialty and obtaining a residency position. Provides valuable information on selecting a specialty, selecting a residency program, and interviewing.

The Ultimate Guide to Choosing a Medical Specialty, Brian S. Freeman, M.D., McGraw-Hill Publication, 2004.

Written by residents for students, this resource profiles the major medical specialties and gives insight on the specialty decision making process.

Web Sites

Careers in Medicine (CiM) hosted by the Association of American Medical Colleges.
<http://www.aamc.org/students/cim/start.htm>

Fellowship and Residency Electronic Interactive Database (FREIDA Online) hosted by the American Medical Association
<http://www.ama-assn.org/ama/pub/category/2997.html>

Choosing a Specialty hosted by the American Medical Association
<http://www.ama-assn.org/ama/pub/category/7247.html>

Medical Specialty Aptitude Test hosted by Dr. Peter Filsinger, et al.
<http://www.med-ed.virginia.edu/specialties/>

Virtual FMIG hosted by the American Academy of Family Physicians
<http://fmignet.aafp.org/>

Which Medical Specialty For You (online brochure PDF) hosted by the American Board of Medical Specialties (ABMS).
<http://www.abms.org/Downloads/Which%20Med%20Spec.pdf>

Journal Articles

Leigh, JP, Kravitz, RL, Schembri M., Samuels, SJ, Shanaz M. **Physician career satisfaction across specialties.** Arch Intern Med. 2002, 162:1577-1584.

Rabinowitz HK, Paynter, NP. **The rural vs urban practice decision.** MsJAMA Online 2002, 287: 112.

Schafer S, Shore W, Hearst N. **Is medical school the right place to choose a specialty.** MsJAMA Online 2001, 285: 2782-2783.

Green, Marianne MD; Jones, Paul MD, John T. Jr., PhD. **Selection Criteria for Residency: Results of a National Program Directors Survey.** Academic Medicine. March 2009, 84:362-367.

How to Obtain Specialty Information Within Your Medical School

The divisions and departments within your own medical school are primary and accessible sources of information about various specialties and residency programs. The Division/Department Information Form on the following page provides an example of the information you might want from various departments in your medical school as you begin to think about specialty selection. You might want to compile all the information from departments and divisions for use by other medical students. The form on the next page contains questions to ask faculty advisors, attending physicians and other physicians with whom you have occasion to discuss your career plans.

Division/Department Information Form for Residency and Specialty Information

Division/Department _____

Telephone Number _____

Faculty Resource Person _____

Title _____

1. Does your specialty Match early?

2. Do programs in your specialty use ERAS?

3. Does the department provide advising on specialty selection and/or resources about the specialty?

4. What advice would you give a student that is interested in pursuing a career in your specialty?

5. What is the long-range outlook for graduates of your specialty?

6. What is your specialty looking for in a resident?

7. What resources are available in your department to help students with residency location selection?

8. Do you have any advice for students about obtaining letters of recommendation from faculty members in your department?

9. Can you comment on how competitive the residency programs are in your specialty?

10. Does your residency program provide international/underserved/rural/community rotations?

11. What portions of a candidate's application do you consider most important?

12. What are you looking for in the interview?

13. What other comments do you have regarding your specialty?

Types of Residency Training Programs

The following is a partial list of the types of accredited residency training available with an indication of the usual course toward completion of training in each specialty. There may be exceptions in prerequisites or in years of training for individual residency programs within a given specialty.

Specialty	Duration of Training
Allergy and Immunology	2 years (Requires completion of three-year internal medicine or pediatric residency.)
Anesthesiology	4 years (includes PGY1 – transitional/preliminary year)
Colon and Rectal Surgery	1 or 2 years (Following completion of a general surgery residency.)
Critical Care Medicine	1 or 2 years (Following completion of an anesthesiology or internal medicine residency.)
Dermatology	4 years (Programs may be four years, or three years following one year in medical or surgical training program.)
Dermatopathology	1 – 2 years (Requires completion of a dermatology or pathology residency.)
Emergency Medicine	3 – 4 years
Family Medicine	3 – 4 years
General Surgery	5 – 6 years
Internal Medicine	3 years
Infectious Disease	2 years (Requires completion of an internal medicine residency.)
Neurological Surgery	5 years (Requires completion of one year general surgery training.)
Neurology	4 years (Programs may be four years, or three years following one year in internal medicine, or another type of training program.)

Specialty	Duration of Training
Nuclear Medicine	3 years (Requires completion of two years “preparatory” training that provides broad experience in clinical medicine.)
Obstetrics-Gynecology	4 years (Programs may be four years, or three years following one year in another type of training program.)
Ophthalmology	4 years (Programs may be four years, or three years following one year in another type of training program.)
Orthopaedic Surgery	5 years (Program may be four years when preceded by general medical specialty residency. Five years includes one year of non-orthopaedic and four years of orthopaedic education.)
Otolaryngology	5 years (Three years progressive training and one additional year in another type of training program. Requires at least one year of general surgery.)
Pathology	4 years (Most programs are four years which includes training in both anatomic and clinical pathology. Some may be three years for either anatomical or clinical alone.)
Pediatrics	3 years
Physical and Rehabilitative Medicine	4 years (Programs may be four years, or three years following one year in another type of training program.)
Plastic Surgery	6 – 7 years (Requires a minimum of three years training in a general surgery residency or completion of otolaryngology or orthopaedics residency.)

Specialty

Duration of Training

Preventive Medicine

Variable years

(Requires completion of (1) clinical phase — i.e., at least one year of training in family practice, internal medicine, pediatrics, obstetrics, or transitional year program, (2) academic phase—Master's of Public Health, (3) practicum phase—one year of supervised application of skills within a field of special study. Types of preventive medicine residencies are (1) public health and general preventive medicine, (2) occupational medicine, (3) aerospace medicine.

Psychiatry

4 years

(Program may be four years, or three years following one year of another type of training program.)

Child/Adolescent Psychiatry

5 years

(Requires two years general psychiatry and two years child/adolescent psychiatry following one year of another type of training program.)

Pulmonary Medicine

2 years

(Following completion of an internal medicine residency.)

Diagnostic Radiology

4 years plus PGY1 – transitional/preliminary year

Radiation Oncology

4 years plus PGY1 – transitional/preliminary year

Rheumatology

2 years

(Following completion of an internal medicine residency.)

Thoracic Surgery

2 to 3 years

(Following completion of a general surgery residency.)

Transitional Year

1 year

Urology

5 years

(Requires two years of general surgery followed by three years of clinical urology training.)

Vascular Surgery

1 or 2 years

(Following completion of a general surgery residency.)

This information is derived in part from the Graduate Medical Education Directory (GMED) published by the American Medical Association. The directory contains the accreditation guidelines for residency training. Additional information also is available in the GMED Companion — An Insider's Guide to Selecting a Residency Program published by the AMA. Check your medical library for copies of these directories or order a copy via the AMA website.

Overview of Positions in Residencies

The various types of residencies are diagrammed below. The length of each bar represents the years of training required for certification by the Specialty Boards. These are unofficial assignments derived from published materials and are offered only for information. Consult the current Graduate Medical Education Directory (the “Green Book”) for the official requirements.

1	2	3	4	5	6 – 7
Family Medicine*					
Emergency Medicine					
Pediatrics		Subspecialties			
Internal Medicine		Subspecialties			
Obstetrics/Gynecology					
Pathology					
General Surgery					Subspecialties
		Neurological Surgery			
		Orthopaedic Surgery			
		Otolaryngology			
		Urology			
Transitional or Preliminary Medicine or Preliminary Surgery	Anesthesiology				
	Dermatology				
	Neurology				
	Nuclear Medicine				
	Ophthalmology				
	Physical Medicine				
	Psychiatry				
	Radiology-Diagnostic				
	Radiation-Oncology				

* Post graduate fellowship options include Adolescent Medicine, Faculty Development, Geriatrics, Research, Global Health, Hospitalist Medicine, Obstetrics, Sports Medicine, and others. More information about these and other options can be found at <http://www.aafp.org/fellowships/>

Other Types of Training Programs

With the exception of Transitional Year Programs, the preceding training programs, called residencies, are recognized as separate specialties and lead to Board certification in those specialties.

Programs that combine elements of two different specialty training programs do not constitute a separate specialty, but are designed to lead to Board certification in both specialties. Combined Internal Medicine-Pediatrics programs constitute the largest group of these combined programs and are listed separately in the Graduate Medical Education Directory. Other types of post-graduate training programs, called fellowships (usually one to two years), may lead to subspecialty certification or specialty certification with added qualifications. The GMED includes some information about available fellowships within each residency program. More specific and comprehensive information is available by contacting medical specialty societies or individual training programs.

Currently, there are three types of dual degree residency programs for family medicine, which require extended training — typically five years total:

- Family Medicine — Emergency Medicine
- Family Medicine — Internal Medicine
- Family Medicine — Preventive Medicine
- Family Medicine — Psychiatry

National Medical Specialty Societies

You can get additional information about various specialties by contacting their respective professional organizations. The following is a list of some of the major medical specialty societies that are recognized by the American Medical Association.

Aerospace Medical Association

320 S. Henry Street
Alexandria, Virginia 22314-3579
(703) 739-2240
www.asma.org

American Academy of Allergy, Asthma and Immunology

555 E. Wells Street, Ste. 1100
Milwaukee, WI 53202-3823
(414) 272-6071
www.aaaai.org

AND

American College of Allergy, Asthma and Immunology

85 W. Algonquin Road, #550
Arlington Heights, IL 60005
(847) 427-1200
www.acaai.org

American Academy of Child and Adolescent Psychiatry

3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016-3007
(202) 966-7300
www.aacap.org

American Academy of Dermatology

P.O. Box 4014
Schaumburg, IL 60168-4014
(847) 330-0230
www.aad.org

American Academy of Facial Plastic and Reconstructive Surgery

310 S. Henry Street
Alexandria, VA 22314
(703) 299-9291
www.aafprs.org

American Academy of Family Physicians

11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
(913) 906-6000 or (800) 274-2237
www.aafp.org
AAFP student site: www.fmignet.aafp.org

American Academy of Neurology

1080 Montreal Avenue
St. Paul, MN 55116
(651) 695-2717
www.aan.com

American Academy of Ophthalmology

P.O. Box 7424
San Francisco, CA 94120-7424
(415) 561-8500
www.aao.org

American Academy of Orthopaedic Surgeons

6300 N. River Road
Rosemont, IL 60018-4262
(847) 823-7186
www.aaos.org

American Academy of Otolaryngology-Head and Neck Surgery

One Prince Street
Alexandria, VA 22314-3357
(703) 836-4444
www.entnet.org

American Academy of Pediatrics

141 Northwest Point Blvd.
Elk Grove Village, IL 60007-1098
(847) 434-4000
www.aap.org

***American Academy of Physical Medicine
and Rehabilitation***

One IBM Plaza, Ste. 2500
330 N. Wabash
Chicago, IL 60611-7617
(312) 464-9700
www.aapmr.org

***American Association of
Neurological Surgeons***

5550 Meadowbrook Drive.
Rolling Meadows, IL 60008
(847) 378-0500
www.aans.org

American College of Cardiology

9111 Old Georgetown Road
Bethesda, MD 20814-1699
(301) 897-5400 or (800) 253-4636
www.acc.org

***American College of Chest Physicians
American Thoracic Society***

3300 Dundee Road
Northbrook, IL 60062-2348
(847) 498-1400 or (800) 343-2227
www.chestnet.org

AND

American Thoracic Society

61 Broadway
New York, NY 10006-2755
(212) 315-8600
www.thoracic.org

***American College of Emergency
Physicians***

P.O. Box 619911
Dallas, TX 75261-9911
800-798-1822
www.acep.org

American College of Gastroenterology

P.O. Box 3099
Alexandria, VA 22302
301-263-9000
www.acg.gi.org

AND

***American Gastroenterological
Association***

4930 Del Ray Avenue
Bethesda, MD 20814
(301) 654-2055
www.gastro.org

American College of Legal Medicine

1111 N. Plaza Drive Suite 550
Schaumburg, IL 60173
(847) 969-0283
www.aclm.org

Society of Nuclear Medicine

1850 Samuel Morse Drive
Reston, VA 20190-5316
(703) 708-9000
www.snm.org

AND

***American College of
Nuclear Physicians Secretariat***

545 Mainstream Drive, Ste. 110
Nashville, TN 37228
(615) 324-2360
www.acnp.snm.org

***American College of Obstetricians
and Gynecologists***

409 12th Street., S.W.
Washington, D.C. 20090-6920
(202) 638-5577
www.acog.org

***American College of Occupational
and Environmental Medicine***

25 Northwest Point Blvd, Ste. 700
Elk Grove, IL 60007-1030
(847) 818-1800
www.acoem.org

***American College of Physicians/
American Society of Internal Medicine***

190 North Independence Mall West
Philadelphia, PA 19106-1572
(215) 351-2600 or (800) 523-1546 x2600
www.acponline.org

American College of Preventive Medicine

1307 New York Avenue, N.W. Suite 200
Washington, D.C. 20005
(202) 466-2044
www.acpm.org

American College of Radiology

1891 Preston White Drive
Reston, VA 20191
(703) 648-8900
www.acr.org

American College of Surgeons

633 N. Saint Clair Street
Chicago, IL 60611-3211
(312) 202-5000
www.facs.org

American Geriatrics Society

Empire State Building
350 Fifth Avenue, Suite 801
New York, NY 10118
(212) 308-1414
www.americangeriatrics.org

American Psychiatric Association

1000 Wilson Blvd, Suite 1825
Arlington VA 22209-3901
(703) 907-7300
www.psych.org

American Society of Anesthesiologists

520 N. Northwest Highway
Park Ridge, IL 60068-2573
(847) 825-5586
www.asahq.org

American Society of Clinical Pathologists

2100 West Harrison Street
Chicago, IL 60612
(312) 738-1336
www.ascp.org

AND

College of American Pathologists

325 Waukegan Road
Northfield, IL 60093-2750
(847) 832-7000 or (800) 323.4040
www.cap.org

***American Society of Colon and
Rectal Surgeons***

85 W. Algonquin Road, Suite 550
Arlington Heights, IL 60005
(847) 290-9184
www.fascrs.org

***American Society of Plastic and
Reconstructive Surgeons, Inc.***

Judy Northrup
Educational Director
444 E. Algonquin Road
Arlington Heights, IL 60005
(847) 228-9900
www.plasticsurgery.org

American Urological Association, Inc.

1000 Corporate Blvd.
Linthicum, MD 21090
(410) 689-3700 or toll free (866) 746-4282
www.auanet.org

Notes

Notes

Section 2

IMG RESOURCES

IMG RESOURCES

Medical schools outside of the U.S. and Canada vary in educational standards, curriculum, and evaluation methods. The information below is intended to provide international medical school students and graduates with basic information on the process for becoming certified to participate in the U.S. residency application process.

Definition of an International Medical

Graduate (IMG): A physician who received their basic medical degree from a medical school located outside the United States and Canada. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. This means that U.S. citizens who graduated from medical schools outside the United States and Canada are considered IMGs. Non-U.S. citizens who graduated from medical schools in the United States and Canada are not considered IMGs.

ECFMG

What is the ECFMG?

The ECFMG is the Educational Commission for Foreign Medical Graduates. It was founded in 1956 to assess whether International Medical Graduates (IMGs) are ready to enter ACGME accredited residency programs in the U.S. You must be certified by the ECFMG before you can start a graduate medical education program. www.ecfm.org

Requirements for ECFMG Certification: IMGs must complete all of the requirements to be certified. The ECFMG will then issue a Standard ECFMG Certificate.

1. Application for ECFMG Certification

- Submit an application for ECFMG certification before applying to the ECFMG for examination
- Application includes: confirmation of identity, contact information, graduation from medical school listed in the International Medical Education

Directory (IMED) list from the Foundation for the Advancement of Medical Education and Research (FAIMER) <https://imed.faimer.org/>, and release of legal claims.

2. Examination Requirements: IMGs must pass Step 1 and Step 2 of the USMLE (United States Medical Licensing Exam) that are the same exams taken by U.S. and Canadian grads. Time limits may apply. Detailed information on USMLE is available at www.usmle.org

- Medical Science Exam
 - o Pass Step 1 of the USMLE
 - o Pass Step 2 CK (clinical knowledge) of the USMLE
- Clinical Skills Exam
 - o Pass Step 2 CS (clinical skills) of the USMLE

3. Medical Education Credential Requirements

- Physician's medical school and graduation year is listed in IMED (International Medical Education Directory)
- IMGs are awarded credit for at least four credit years of medical school
- Documentation for completion of all credits, and receipt of a final medical diploma
- Final medical school transcripts

The Certification Process

The first part of the certification process starts when you apply to ECFMG for a USMLE/ECFMG identification number. Once you obtain this number, you can use it to complete the Application for ECFMG Certification. Once you submit your Application for Certification, you may apply for examination.

Medical students and graduates can both begin the certification process. Since one of the requirements of certification is the verification of your medical school diploma, you cannot complete the process until you are graduated.

You can apply for the required exams as soon as you meet the exam eligibility requirements. All of the required exams are offered continually throughout the year.

Applying to Graduate Medical Education Programs

FREIDA is the online directory of graduate medical education programs sponsored by the American Medical Association. The AAFP also offers a family medicine residency directory which can be accessed online. For each medical specialty, there is specific information on individual programs and any general or special requirements for application. Application deadlines may vary among the programs and you should contact programs directly about their deadlines.

ERAS is the application service: Most programs require applicants to submit their applications using the Electronic Residency Application Service (ERAS). The ECFMG coordinates the ERAS application process for IMGs. www.ecfm.org/eras

The NRMP is the mechanism for connecting programs and applicants: The National Resident Matching Program (NRMP) also coordinates "The Match" for US, Canadian and IMG students and graduates. If you wish to participate, you must register with the NRMP and submit the needed materials. View Section 6 in this book on "The Match" to learn more detailed information about how the process works.

Residency Program Requirements

Many residencies list their program's requirements for applicants on their websites, such as medical school graduation year, type of visas accepted, or number of attempts on USMLE exams. Investigate residency requirements to direct the submission of your applications appropriately.

The Scramble, or the SOAP?

The Scramble is the period of time after the Match when applicants who did not match attempts to find and try to obtain one of the remaining unfilled residency positions. 2012 will mark the last year for this process to take place.

The NRMP offered the SOAP (Supplemental Offer and Acceptance Program) as a replacement for the managed "Scramble" program. The SOAP is scheduled to launch Match Week 2012. Some residency programs will participate in the Match and the SOAP, but others may still fill all of their positions outside of the Match.

Because offers made and accepted during Match Week will be binding under the Match Participation Agreement, only applicants eligible to begin training on July 1 in the year of the Match will be allowed to participate. The NRMP will exchange data with the ECFMG to recertify the status of IMGs.

View Section 7, The SOAP, in this book to find more information about this new process.

Obtaining a VISA

To participate in U.S. graduate medical education programs, IMGs who are not citizens or lawful permanent residents must obtain the appropriate VISA. The two most common VISAs are the H1-B (Temporary Worker) or the J-1 (Exchange Visitor). Some institutions will sponsor the VISA for residents in the residency program. The ECFMG is also authorized by the US Department of State to sponsor foreign national physicians for the J-1 VISA. Questions on obtaining a VISA should be directed to your residency program staff the US embassy or consulate in your country of residence or the U.S. Citizenship and Immigration Services.

Resources

ECFMG Website: the complete guide to the process for application for certification, important dates, application materials and publications including:

ECFMG Information Booklet

Reference Guide for Medical Education Credentials

International Medical Education Directory (IMED)

The ECFMG Reporter – free newsletter

VISA Information

U.S. Citizen and Immigration Services
www.uscis.gov

U.S. Department of Homeland Security
www.dhs.gov

Graduate Medical Education Resources

AAMC ERAS Website
www.aamc.org/students/eras

National Resident Matching Program (NRMP)
www.nrmp.org

Graduate Medical Education Directory
www.ama-assn.org

AAFP Directory of Family Medicine Residency Programs
www.aafp.org/residencies

Notes

Notes

Section 3

PREPARATION

PREPARATION

Preparing Your Credentials

This section will give you some pointers on how to prepare your curriculum vitae, a personal statement and letters of reference, including a letter from your dean's office now referred to as the MSPE, which are necessary to apply for a residency training position.

How to Prepare Your Curriculum Vitae

Though you may not have prepared a formal CV ("course of life"), you are already familiar with its function and the type of information needed from your applications for employment, college, or for that matter, medical school. One of the primary functions of a CV is to provide a succinct chronicle of your experience and training.

In a sense, a CV is a multi-purpose, personal application form for employment, educational opportunities, honors and awards, membership or participation in an organization.

Learning to prepare a good CV now will help you throughout your professional life. It is a living, not a static, document that must be continually updated as you complete new experiences or accomplishments. Despite its multiple purposes, your CV must be restructured and rewritten, or at least reviewed, for each purpose for which it is to be used. It might be entirely inappropriate to include a lengthy list of publications in a CV you are submitting as application for membership in a volunteer organization. On the other hand, it might be imperative to include this information, if not in the body, at least as an appendix, in a CV you are submitting for an academic position.

Some experts recommend maintaining two versions of your CV — a short summary of your training and experience and a longer version with more detailed information about your publications and presentations. In general, however, no CV should be lengthy. No matter how many accomplishments you list, you won't impress anyone if they can't quickly pick out two or three good reasons to choose you over

someone else. Let your CV help you put your best foot forward.

Sometimes, a CV is referred to as a "résumé." Academic or educational circles tend to use the word curriculum vitae, or CV, more frequently than résumé. Because of the nature of the medical profession, where the years for preparation are highly structured and generally comparable from institution to institution, a chronological format for the medical CV is often preferred.

Many reference books offer advice on different formats for preparing CVs and résumés. Some of these are listed on page 32.

HERE ARE SOME TIPS TO HELP YOU GET STARTED:

General Tips

- A chronological CV should be arranged in reverse chronological order. It should be apparent immediately where you are now.
- Remember that an application form is limited to the few things that a particular institution wants to know about everybody. A CV lets you give information that is unique to you. Add all your key accomplishments and activities in the initial draft. In subsequent drafts, you can remove information that may not be pertinent.
- Resist the temptation to append explanatory sentences or language, which will distract the reader from the basic information being presented. The language of a CV is abbreviated and succinct. When applying for residency training, you will have the opportunity to express yourself in a personal or biographical statement. In the future, when applying for a job or some other type of position, you will want to include an appropriate cover letter with your CV to explain your particular qualifications and strengths for the position.

- Don't despair if your CV doesn't resemble those of other students who are applying to the same residency program. Everybody's CV is different. Even if everyone used the same format suggested in this section, your CV will not resemble others' because it doesn't have the same content. No residency program director is looking for a specific CV style. You will receive points for neatness and readability.
- Be honest. If you haven't accomplished anything in a particular category, leave it out. Don't create accomplishments to fill in the spaces. You can be specific about your level of participation in a project or activity, but don't be misleading (i.e., you can say you coordinated membership recruitment for your AMSA chapter, but don't say you were "president" unless you were).

If you still need more information, contact your dean's office. They may be able to share samples and provide additional guidance.

Personal Data

Give your full name. Make sure you can be reached at the address, telephone number and e-mail address that you list. Use a professional e-mail address that you check often. For example, if your current personal e-mail address is /hotmedstudent@hotmail.com, you might want to create a more professional address like Janedoe1@gmail.com. You should check each frequently. Include hospital paging phone numbers, if appropriate. Indicate if there are certain dates where you can be reached at other locations.

You can include some personal information, such as date of birth and marital status, at the beginning of your CV or you can summarize it all in one section, if you choose to add it at all.

Remember that federal law prohibits employers from discriminating on the basis of age, race, sex, religion, national origin or handicap status. Therefore, you do not have to provide this information. Discrimination on the basis of sex includes discrimination on the basis of child-

rearing plans (i.e., number of children or plans to have children).

Although the following items appear frequently, they are probably not necessary and probably should not be included in a CV: social security numbers, licensure numbers and examination scores. If this information is pertinent to your candidacy, the program will request it on the application or at some later point in the application process.

Education

List your current place of learning first in your CV. Include the name of the institution, the degree sought or completed, and the date of completion or date of expected completion. Remember to include medical school, graduate education and undergraduate education. Omit high school.

Later, you will add separate categories for "Post-graduate Training" (includes residencies and fellowships), "Practice Experience," "Academic Appointments," and "Certification and Licensure."

Honors and Awards

Any academic, organizational or community awards are appropriate, but you must use your own judgment as to whether an achievement that you value would be valuable to the person reading your CV.

Professional Society Memberships

List any professional organizations to which you belong and the years of your membership. Include leadership positions held, if any.

Employment Experience

List the position, organization and dates of employment for each work experience. Confine this list to those experiences that are medically related (i.e., med tech, nurse's aide, research assistant, etc.) or that show breadth in your work experience (i.e., high school teacher, communications manager, etc.).

Extracurricular Activities

List your outside interests or extracurricular activities. These help develop a broader picture of your personality and character. Also, any special talents or qualifications that have not been given due recognition in other parts of the CV should be highlighted in this or a separate section. For example, you'll want to include things like fluency in other languages or a certification such as a private pilot's license.

Publications/Presentations

List any papers you published or presented by title, place and date of publication or presentation. If this list is very lengthy, you may want to append it separately or note "Provided Upon Request."

References

You may be asked to provide both personal and professional references. These names may be included in the CV, appended as part of a cover letter or application form, or noted "Provided Upon Request."

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Please note — Although CVs are not included as one of the standard ERAS application documents, programs can create and print out a report, based on information in your application, in a CV format. Developing a CV, however, remains a useful exercise because it provides most, if not all, of the information needed to complete the ERAS application. Having this information before the dean's interview may reduce the amount of time you spend completing the ERAS application. In addition, some programs may require the CV as supplemental information; therefore, applicants should consider having the CV available during interviews, should it be required by the program. Your designated dean's office cannot attach your CV to your ERAS application; however, you can view how your MyERAS information will appear to programs by electing the option to print or review your common application form in a CV format in MyERAS.

SAMPLE CURRICULUM VITAE

JESSICA ROSS

ADDRESS

3800 Hill Street
Philadelphia, Pennsylvania 19105
(813) 667-1235 (home, after 6 p.m. EST)
(813) 667-4589 (hospital paging)
jross@gmail.com

EDUCATION

University of Pennsylvania-School of Medicine, M.D., expected May 2010
University of Pennsylvania, M.S. in Biology, June 2003
Oberlin College, B.S. in Biology, June 2002

HONORS AND AWARDS

Family Medicine Interest Group Leadership Award, 2007
Outstanding Senior Biology Award, Oberlin College, 2001
Dean's Award, Oberlin College, 2001

PROFESSIONAL SOCIETY MEMBERSHIPS

American Academy of Family Physicians, 2006 to present
Pennsylvania Academy of Family Physicians, 2006 to present
American Medical Association, 2006 to present
Pennsylvania Medical Society, 2007 to present

EMPLOYMENT EXPERIENCE

Venipuncture Team U-P University Hospital
Teaching Assistant, University of Pennsylvania, Biology Department

EXTRACURRICULAR ACTIVITIES

Family Medicine Interest Group, 2006 to present
Youth Volunteer – Big Sisters
Outside Interests – Piano, poetry, reading, running, walking, cycling, travel
Special Qualifications – Private pilot license, 2001. Fluent in French

PUBLICATIONS

Ross, Jessica, Robert Phillips, Andrew Bazemore. Does Graduate Medical Education Also Follow Green. *Arch Internal Medicine*. 2010;170(4):389-396.
"Make Time to Get Involved in Your Community", The Community Service Connection, Spring 2002.
"10 Tips for Effective Leadership," *AAFP News Now*, Fall 2009.

SUGGESTED BOOKS ON CVS AND RÉSUMÉS

- *175 High Impact Résumés*, Richard Beatty, John Wiley and Sons, 3rd Edition, 2002.
- *Résumés*, Taunee Besson, Perri Capell, John Wiley and Sons, 3rd Edition, 1999.
- *Résumés and Personal Statements for Health Professionals*, James Tysinger, Galen Press, Ltd. 2nd Edition, 2001.
- *Résumés for Better Jobs*, Lawrence Brennan, Stanley Strand, Edward C. Gruber, IDG Books
- *The Perfect Résumé*, Tom Jackson, Ellen Jackson, Main Street Books, 1996.
- *The Résumé Makeover*, Jeffrey Allen, John Wiley and Sons, 2001.

You can find many more titles at your local library or bookstore. Some libraries offer online videos dedicated to CV and résumé writing that you can check out. And most cities probably have at least one résumé writing service available.

HOW TO WRITE A PERSONAL STATEMENT

A part of every application process is the preparation of a personal or autobiographical statement. Generally speaking, the application forms for residency positions will request a personal statement. In other instances in which you are preparing your credentials for a job or another type of position, you will want to include the substance of a personal statement in the form of a cover letter to your CV.

If you will not participate in ERAS and will complete a paper application, the personal statement serves to complement and supplement your CV with a description of your qualifications and strengths in narrative form. Like a CV, it is written for a specific purpose or position. You want to convey to your reader how and why you are qualified for the position to which you are applying. In the case of a

residency position, you want to emphasize the reason for your interest in that specialty and in that particular program.

Feel free to highlight items in your CV if they help remind your reader of the experiences you've had that prepared you for the position. This is your opportunity to expand upon activities that are just listed in the CV but deserve to be described so your reader can appreciate the breadth and depth of your involvement in them.

You may choose to relate significant personal experiences, but do so only if they are relevant to your candidacy for the position.

Lastly, the personal statement is the appropriate place to specify your professional goals. It offers the opportunity to put down on paper some clear, realistic, and carefully considered goals that will leave your reader with a strong impression of your maturity, self-awareness and character.

The importance of good writing cannot be overemphasized. The quality of your writing in your personal statement is at least as important as the content. Unfortunately, not only are good writing skills allowed to deteriorate during medical school, but in some sense, they also are deliberately undermined in the interest of learning to write concise histories and physicals. For the moment, forget everything you know about writing histories and physicals. While preparing your personal statement:

- Write in complete sentences.
- Avoid abbreviations — don't assume your reader knows the acronyms you use. As a courtesy, spell it out.
- Avoid repetitive sentence structure.
- Avoid using jargon. If there is a shorter, simpler, less pretentious way of putting it, do so.
- Use a dictionary and spell check. Misspelled words look bad.
- Use a thesaurus. Variety in the written language can add interest — but don't get carried away.

- Get help if you think you need it. For a crash course in good writing try *The Elements of Style*, Strunk and White, MacMillan Press, Fourth Edition. If you have a friends or relatives with writing or editing skills, enlist their help. In any case, give yourself enough time to prepare a well-written statement. Remember, in the early part of the residency selection process, your writing style is the only factor your reviewers can use to “know” you personally.

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ERAS lets applicants create one or more personal statements that can be earmarked for specific programs. Some programs ask applicants to address specific questions in their personal statements.

ERAS includes a simple text editor for typing your personal statements; however, you may complete your personal statement using word processing software that lets you make changes more easily and take advantage of the available editing features, such as spell check. After you’ve completed the final text, save your document as a text file. Then use the “cut and paste” feature to add your information to the personal statement section of your ERAS application. Before you assign the personal statement to a program, print a copy for review to ensure there are no hidden page breaks or special characters embedded from the word processor. Your personal statement(s) must be assigned individually to each program. The MyERAS Web site has a link that describes how to complete the document and assign personal statements to individual programs using MyERAS.

TIPS ON LETTERS OF REFERENCE

Programs may ask you to submit both personal and professional letters of reference. Most people don’t have any problem identifying personal references. Letters of reference from particular department heads or faculty present the greater problem.

These letters can be very valuable to program directors looking for some distinguishing characteristics among the many applications they receive. After reading this manual, everyone will know how to write a good CV and personal statement. The quality of your letters of reference may be the strength of your application.

The following outline tips on letters of reference were developed by the Department of Family Medicine with contributions from medical students at the University of Washington in Seattle. (Leversee, Clayton and Lew, Reducing Match Anxiety, University of Washington, Department of Family Medicine.)

A. Importance

Your letters of reference often become an important reflection of your academic performance and can also serve as an important source of information about your non-cognitive qualities.

B. Number of Letters

1. Most residency programs request three letters of reference. Sometimes they specify certain departments or rotations from which the letters should originate. You will only be able to submit four LORs to any given program through ERAS.
2. Be sure to follow directions from the program brochure. For example, some programs will require letters from particular departments, others require letters from attendings rather than residents. Occasionally, a letter from a person not involved in the profession of medicine will be requested.

3. Do not send more letters than requested unless you have one that is especially dazzling. Some selection committees suspect “the thicker the application, the thicker the student.” Some programs review only the first letters to arrive up to the number they request, and subsequent letters are ignored.

C. Timeline

1. Starting

- a. It is easy to procrastinate. Common reasons include:
 - “I don’t know anyone well enough to ask for a letter.”
 - “I hate asking for recommendation letters. I’ll wait until August.”
 - “I did well on surgery, but that was six months ago. They won’t remember me.”
 - “Dr. Scholarmann is on sabbatical; I’ll just wait until he gets back.”
 - “I’m an average student, so I’ll just get a two-liner from one of my attendings later. A quick phone call will solve that problem when the time comes.”
 - “I’ll really impress them on my next rotation and get the best letter yet.”
- b. As a courtesy, make arrangements for obtaining letters as soon as possible. You may begin now by requesting letters from previous rotations. Sometimes there is a real advantage in postponing a letter request until you have had a specific rotation if it is obviously an important one for your particular interest.
- c. Allow at least a month from the time you request a letter until it must be delivered. Bear in mind that faculty are often out of town and that faculty members usually have multiple letters to write.

A. Requesting a Letter

1. In most instances, you will request a letter from a rotation in which you did well, that relates to your chosen field or that was requested by the program brochure.
2. When possible, choose someone who knows you well over someone who doesn’t. Choosing at least one person who is likely to be recognized by the program is also a good idea. Choose someone who can judge your clinical skills and intentions, not just a friend.
3. Letter from a mentor in specialty of choice.
4. Avoid requesting a letter from a resident or fellow. They may have the best command of your clinical skills but the attending should write your letter. Help the attending by providing the names of the residents and fellows with whom you worked so the attending can consult them for input if needed.
5. Help the person preparing your letter by providing a curriculum vitae, a personal statement and a photograph.
6. Make an 15-minute appointment with the letter writer to review your CV personally. Help the letter writer with additional personal information, particularly if you can remind him or her of a specific event or situation in which you think you performed well on his or her rotation.

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ERAS allows you to request as many letters of reference as you deem necessary; however, MyERAS will allow you to assign a maximum of four letters to each program. For example, you may request letters of reference from twenty (20) different individuals. However, you may assign only a maximum of four of the twenty letters to each program. Writers must submit the letters directly to your designated dean's office. Talk to your designated dean's office to determine their preferred format. MyERAS can print an instruction memorandum customized for each writer. The memorandum explains how to prepare the letter of reference for ERAS and where the letter should be sent. Follow up with letter writers to ensure that the letter arrives in a timely manner and check with your designated dean's office to ensure that the letters have arrived in advance of your first application deadline. Consider having a back-up letter in the event that one does not reach the dean's office before your established deadline.

WHAT ABOUT THE MEDICAL SCHOOL PERFORMANCE (MSPE)?

Sometimes, the MSPE is also referenced by students and others as the dean's letter. The MSPE is an important part of your application for residency training. Guidelines have been created to assist medical schools with developing an evaluative tool indicative of the applicant's entire medical school career. The process of creating a MSPE in many schools entails a meeting with your dean or his/her designee so it can reflect some personal insight into your performance and career goals.

As with the dean's letter, November 1 is the standard release date for the MSPE. Whether you're applying to all of your programs via ERAS or via other channels, schools will not release the MSPE until November 1. ERAS is programmed to embargo the MSPE at the ERAS PostOffice until 12:01 a.m. on November 1. The only exception is MSPEs for fellowship applicants. They are available to fellowship programs as soon as they are transmitted from the EFDO.

Other questions you will want to address in preparation for the MSPE are:

- When can you begin scheduling appointments to visit with the dean?

- Whom should you contact to schedule an appointment?
- What resources should you have in preparation for your meeting with the dean? Should you have a draft of your CV and personal statement ready? What other information, such as transcripts, list of potential residency programs, etc., should you bring along?
- How do you obtain the MSPE to send to residency programs that are not participating in ERAS?
- How long does it take for the MSPE to be drafted, signed and sent out?
- Will you have the opportunity to review your MSPE before it is sent out?

Misdemeanor/Felony Questions

Applicants are now required to answer questions concerning whether or not you have been convicted of a felony or misdemeanor.

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Section 4

SELECTING A PROGRAM

RESIDENCY SELECTION STEPS

There are three steps to the process of selecting a residency program. The objectives of the first step are identifying the factors that are most important to you in the decision-making process, beginning researching programs and identifying those that you want to learn more about. Your research and the decision-making process should focus on collecting objective information, such as community size, region, call schedule, etc. The Web sites of individual residencies, online and published residency directories, and suggestions from others will be important sources of information for this phase in process. Don't be afraid to attend local, regional or national meetings to help you.

The second step of the process begins after you have completed your due diligence in phase one. The objectives of the second phase are to collect subjective information, identify pros and cons for each program that interests you and prepare a preliminary roster of high priority programs you want to visit for interviews. To get this information, talk to community physicians, alumni from the residency and classmates who have completed electives at those programs. Also, plan to attend conferences and residency fairs.

The face-to-face interaction at these events is a good touchstone, without the pressure of an interview or elective, for reconciling your interests with the pros and cons of a program. These events are also an efficient way to compare many different programs at one time. An example of a national meeting that lets students visit with many residencies in one location is the AAFP's National Conference of Family Medicine Residents and Medical Students, held each summer in Kansas City, Missouri. To learn more about this meeting visit the National Conference Web site at <http://www.aafp.org/nc>

The third step includes interviewing at a carefully selected group of programs and placing each program in a rank order based on pros and cons for each program. After interviewing, you should have a considerable amount of information about each of the programs in which you are interested. Creating the rank order list is your final task. In this final phase, students often find it helpful to use a logical tool such as modified decision table to help quantify the pros and cons for each program. Decision tables give students a systematic way of assessing and comparing each program by the factors that are most important to them.

Sample Modified Decision Table

Factors	Weight (W)	Program 1 -	Rating(R)	W * R	Program 2 -	Rating(R)	W * R
Facilities	8.5	Comments here	4	34	Comments here	7	76.5
Electronic Health Record	7	Comments here	9	56	Comments here	4	56
Curriculum	8	Comments here	9	72	Comments here	9	72
Faculty	9	Comments here	7	56	Comments here	8	72
Location	10	Comments here	4	40	Comments here	9	90
Community size	2	Comments here	5	10	Comments here	8	16
Total		Total Score:	268	Total Score:	382.5		

Additional Tips

Many students consult the Graduate Medical Education Directory or the online version known as FREIDA, a database with more than 8,600 accredited graduate education programs. These resources will provide information such as the name of the program director, the hospital, the number of hospital admissions, outpatient visits and available residency positions.

<http://www.ama-assn.org/ama/pub/category/2997.html>

- Don't eliminate a program because you think or assume that you are not a strong enough candidate. You really don't know that until you've gotten through the first stages of the applications process, so don't let anyone discourage you.
- Keep an open mind about the quality of each program. Even though you may have never heard of St. Someone's Hospital, it might have an excellent program. There are too many residency programs in each specialty for anyone to keep a running tab on which is the best program.

Different programs excel for different reasons and individual residency candidates may value the same program for different reasons. As a result you won't find "top ten" lists for residency programs. Your objective is to find the training program that best meets your unique goals.

A few specialty societies (American Academy of Family Physicians and American Psychiatry Association for example) have developed their own residency directories, which are accessible on the Web. These directories include information on frequency of call, number of graduates from the program, number of residents in each training year, number of faculty, salary and benefits, etc. If you are interested in these specialties, look for these directories in your medical library or contact the respective specialty societies (see list of National Medical Specialty Societies beginning on page 22).

Your medical library or the department chair in your medical school may keep files on residency program information. The chair and other faculty members in the department may have firsthand information about some programs and can give you guidance about the amount of variance among different programs in their specialty. You may want to ask them which programs they consider to be the "best" and why. Ask them why they chose their own training programs.

Finally, many medical schools are willing to provide the names and residency locations of previous graduates. Consider contacting those physicians who are doing their residencies in your chosen field and ask them why they chose their programs and what other programs they considered.

If you are satisfied with the amount of information you have, you are ready to return to a period of self-analysis to determine which programs are most likely to meet your needs and are therefore worth applying to. Again, there is no penalty for making an initial application to as many programs as you want, but consider whether it is worth the cost for both you and the programs if you already know you're not interested.

Based on what you know about yourself, your career goals, and about each program, what factors are important or even crucial to your choice of a residency program? Could you definitely include or exclude a program on the basis of a single criterion? What is the relative importance of the following factors?

- Geographic location
- Type of institution
- Age and stability of program
- Academic reputation
- Frequency of call
- Faculty to resident ratio
- Number and type of conferences
- International electives
- Structure and flexibility of curriculum

- Provisions for maternity/paternity leave
- Availability of shared or part-time residency positions
- Physical characteristics of the hospital — age, atmosphere, etc.
- Presence of other training programs in hospital
- Patient population-racial, gender-based and socioeconomic mix
- Community — housing, employment opportunities for spouse/significant other, recreational activities, etc.
- Opportunities for further postgraduate training in same hospital.

Other important factors may not be on this list. Whatever your criteria, let your rational assessment of your needs determine which options to pursue. After you have sent your application, initiated the MSPE process, and transmitted your transcripts and reference letters, you must now wait to see if you are invited to interview. Assuming that you are invited to interview or that you plan to visit most of the programs on your list, you should once again review your list to determine if there are programs you can eliminate based either upon new information or careful reconsideration.

You may have as few as three or as many as two dozen or more programs where you plan to interview. You may have doubts about your list and at the last minute reinsert a few programs. In any case, accept the margin of doubt and have confidence in your ability to think rationally. After all, you've pared down an endless variety of options into a manageable group of choices.

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MyERAS provides a list of all programs eligible to participate in ERAS 2011/2012 along with basic contact information. Programs not participating in ERAS 2011/2012 are included for informational purposes, but cannot be selected. Applicants should contact these programs for their application materials. Some programs may have more than one program track to which applicants may apply. Exercise caution when selecting programs; ERAS fees are based on the number of programs selected. Be sure to contact programs for their requirements, deadlines, and other information BEFORE you select them using MyERAS. A selection based upon the information in MyERAS is not sufficient for your career decisions.

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Section 5

THE INTERVIEW PROCESS

INTERVIEWING TIPS

This section provides tips on all aspects of the interviewing process. It summarizes the guidance of students, residents and program directors on how best to prepare for and succeed in an interview.

Goals of the Interview

The residency interview is a critical stage in the process of residency selection. All the months of paperwork preparation finally rewards you with the chance to find out how the programs on your list actually compare with one another.

The key objectives for your interview can be summarized with three goals:

- 1) Assess how compatible you are with the program and how well the program meets your stated goals.
- 2) Convey your sense of compatibility with the program to those faculty members, residents and staff who interview you. This goes beyond making a good impression. In a sense, you are “trying the program on” or demonstrating to the faculty and residents of the program that you would be a welcome addition to their ranks. Indeed, you may want to think of your interview as an exercise in role-playing with you in the role of a recently matched resident in that program.

Role-playing is not the same as acting. In your eagerness to charm and impress your interviewers, avoid insincerity. Your interviewers want to find out who you really are. It doesn't serve anyone's purpose for you to give a false impression.

- 3) Assess the program's relative strengths and weaknesses so that you will be able to structure a justifiable rank order list.

Be careful not to let your attention to the third goal obscure the need to attend to

the first two. The residency candidate who prepares, in advance, to address all three goals will increase the chance of having a successful match.

The goals of the programs during the interview process are similar to those of the residency candidate. They seek to confirm and expand upon the information that you provided in your application. They are also trying to determine how compatible you would be with the residents and faculty in the program. Just as you are trying to put your best foot forward, the representatives of the residency program want to show their program in the best possible light. However, it is ultimately not in the best interest of the program to paint a misleading picture. Like you, your interviewers are attempting to shape their rank order list of their candidates for the Match.

In short, the residency interview is a delicate and complicated interaction, which adds substance to the selection process for both the candidates and programs.

The following tips will help you to plan for productive and enjoyable interviews.

Scheduling

- Most programs, participating in the NRMP, schedule interviews from September through January. You will hear some differences of opinion as to whether it is better to be one of the first, middle, or last candidates that a program interviews. Since no evidence demonstrates that timing makes a difference in how the program ranks a candidate, and you don't have complete control over the timing of your interview, try not to be anxious about it.
- There is general agreement, however, that you should schedule the interview for your most highly valued program after you have had some experience with one or two interviews in other programs.

- Call to confirm your appointment about a week before your scheduled interview. This will give you an opportunity to reconfirm the place and time of your meeting, who you are going to meet first and perhaps some other details such as where you should park, etc.
- Generally speaking, an interview will take one full day, though you may be invited to meet with one or more residents and faculty for dinner the night before. If your travel schedule permits, allow some time to tour the community outside the program and/or spend some informal time with residents or faculty.
- If your spouse or significant other will be accompanying you on your interviews, you may want to schedule additional time to assess other aspects of the program and community important to him/her. In general, spouses and significant others are welcome to participate in the interview process, but you should clarify this with the program ahead of time so that the schedule can be structured to accommodate this. Some programs specifically provide for the participation of spouses and significant others with organized tours of the community, etc.

Research

- Just before the interview, take time, again, to review the information you've received from the program and any material you may have gathered from other sources. Write down the "facts" that you want to double-check as well as any initial impressions you may have formed based on the written material. Pay special attention to the names and positions of people you are likely to meet.
- You can actually learn a fair amount about the surrounding community before you arrive by checking resources, such as your local library, in your current location. Newspapers from that community can tell you about job opportunities for your spouse/significant other, cultural offerings, the housing market, community problems, etc. Local telephone directories may give

you a better idea of available support services. Check your local bookstore, travel agency, and auto club for guidebooks on the area. Community Web sites also provide a wealth of information.

- Remind yourself of the specific questions you had about this program and write them down in a convenient place so that you will be sure to ask them. It's a good idea to have some thoughtful questions prepared ahead of time to let your interviewers know that you've really given some thought to the qualities of their particular program. Interviewers get tired of answering the same questions, just as you do, so try to think of a few that reflect your own special interest.
- You may have already formulated a list of standard questions that you want to ask every program for comparison, or you may have developed a checklist of program characteristics to fill out in each interview. Appended to this section are two examples of residency interview checklists, one developed by Dr. J. Mack Worthington of the Department of Family Medicine at the University of Tennessee and the other developed by Dr. Joseph Stokes, Jr., who was, at the time, a resident at the Barberton Citizens Hospital Family Practice Residency Program in Barberton, Ohio. Although the latter checklist was developed specifically for the evaluation of family medicine residencies, its structure and most of its content are applicable for use in other types of residencies.

Attitude

- Keep in mind your goals for the interview in order to establish the right frame of mind. Again, you want to project a positive, confident, and enthusiastic demeanor without being overbearing or insincere.
- If you keep in mind that the interviewers have their own agenda to fulfill, you won't be dismayed or intimidated by the tougher questions that try to find out more about you. In fact, if you've thought about what

the interviewers are trying to get out of the interview, you will have already anticipated their questions and have a well-thought-out answer ready.

- Try to be open and honest. It's okay to be nervous, but don't let your nervousness hide your personality.

The Fine Points

These are the things that go under the heading of "common sense" but perhaps bear reiteration.

- In terms of appearance, the general advice is to be neat and comfortable. Use your own judgment as to whether an expensive suit would add to your confidence level or compete with your personality.
- Be on time; better yet, be early. Allow yourself time for finding a parking space, getting to know your surroundings, catching your breath and arriving in place before the appointed hour.
- Before you leave the house, make sure you have everything you need for the interview such as your notes, paper and pen, PDA and an extra copy of your credentials.

ELEMENTS OF THE INTERVIEW

Structure

- Often, the residency program will have prepared your itinerary, listing the names of the people you're going to meet and the amount of time — generally 20 to 30 minutes — allotted for each person.
- In addition to the program director, you want to have a chance to talk to other faculty members, residents from different levels of training, as well as any other individual with whom you would have significant contact as a resident in that program.
- Remember that all members of the faculty and staff may be critiquing you as soon as you start an interview.

- In terms of location, you want to have a chance to see both the hospital and clinic facilities during your interview. If there is free time, spend it in places where there are residents to get a better feel for the actual working environment.

Content

- Decide ahead of time which questions you want to ask of which type of person (i.e., a question about the details of the call schedule might be reserved for the chief resident). On the other hand, there may be some questions you will purposefully want to ask of everyone to see if there is any discrepancy — such as a question about the attending and resident interactions.
- Avoid dominating the conversation, but try to be an active participant in the interviewing process so your interviewer will have a sense of your interest in the program and your ability to formulate good questions.
- Be prepared for different interviewing styles and adjust accordingly.
- Some of the questions that you can expect to be asked include:
 - Why did you choose this specialty?
 - Why did you choose to apply to this residency?
 - What are your strong points?
 - What do you consider are your weaknesses?
 - What are your overall career goals?
 - How would you describe yourself?
 - What do you do in your free time?
 - Describe a particularly satisfying or meaningful experience during your medical training. Why was it meaningful?

Prohibited Questions

According to federal law, you do not have to answer certain questions. It is illegal to make employment decisions on the basis of race, color, sex, age, religion, national origin, or disability. To avoid charges of discrimination based on any of these protected classes,

many employers do not ask questions that would elicit this type of information during an employment interview.

Discussion of Parental Leave, Pregnancy and Child-Rearing Plans

A frequent area of concern during the interview process is questions related to pregnancy and child-rearing plans. The prohibition against discrimination on the basis of sex includes discrimination on the basis of pregnancy and child-rearing plans. You do not have to answer questions related to marital status, number of children, or plans to have children, but you may want to prompt a discussion of the provisions for maternity/paternity leave and/or child care responsibilities in the residency program. Federal regulation provides for 12 weeks of maternity/paternity leave; state regulations may provide for more than 12 weeks of leave (check your state regulations for this information). The law does state, however, that the amount of time allowed for maternity/paternity leave must be the same as that which is provided for sick or disability leave.

Taking Notes

Usually you will find that you don't have enough time to ask all the questions you would like during the interview. It's a good idea to take some notes in your notebook or PDA throughout the day to jog your memory about significant comments, concerns, particularly good points or particularly bad points. Don't concentrate on your notes so much that you interfere with effective interchange during the interview. Instead, note your impressions right after the interview. Using standard questions from all interviews will help you compare responses across the multiple residency programs you interview.

QUESTIONS TO CONSIDER ASKING AT THE INTERVIEW

Questions for Faculty

- Where are most of your graduates located and what type of practices are they going into from residency?
- How do you perceive that your program compares to other programs?
- What kind of feedback are you hearing from your graduates?
- Are some rotations done at other hospitals?
- Are any other residency programs in-house?
- How and how often is feedback provided to residents?
- How would you describe the patient demographics?
- What community service programs does your residency participate in?

Questions for Residents

- What was the most important factor that made you decide to come to this program?
- What are your plans after graduation?
- What's a typical week, month, year like for a first year, second, and third year?
- What is call like? What kind of backup is provided?
- When leave of absence becomes necessary, what happens?
- How do you deal with the stress of residency?
- If there are other residency programs in-house, how do you view their presence?
- What do you/other residents do outside the hospital for community service and for fun?
- Where do you feel most of your learning is coming from?
- What are the program's areas of strength?
- What are the program's areas where improvements could be made?

FOLLOW-UP

Immediately Afterwards

- As soon as possible after the interview, write down your impressions and update your checklist.
- When you get home, send a thank you note to recognize their hospitality and to reaffirm your interest in the program.
- In reviewing your notes, you may discover several vital questions that you did not have the opportunity to ask during the interview. It is perfectly acceptable to call back for more information, particularly if one of your interviewers, frequently a resident, has invited you to contact him or her for more information.

Second Looks

Some programs will offer you the opportunity for a “second look.” Feel free to take advantage of the invitations if you feel it would help you. In some cases, programs will interpret your interest in a “second look” as an indication of your enthusiasm for the program. In other cases, a program may discourage “second looks” and interpret it as an insult if you request one. Try to get some insight into this issue when you talk to the residents in the program.

THE NEXT STEP

After you have completed your interviews, the lion’s share of your work is done. Your only remaining task is to assess the information you have collected and use it to establish your rank order list. You may decide, after completing your scheduled interviews that you still haven’t found what you wanted and think that you’d better look at some more programs. Don’t be too frustrated if you feel you have to do this. It’s better to put in a little extra legwork now than to have lingering doubts later.

Take time to decide how to rank the programs you visited. You may want to put your notes aside for a while to give yourself some time to air your thoughts. Talk through your reasoning with advisors, friends and family, but remember that the final decision is yours. The next section will help you understand how the Match works so that you can make sure your decisions are accurately reflected on your rank order list.

SAMPLE CHECKLISTS

Program _____ Date _____

Overall Rating

(Rating 1 to 5)

1=Poor; 2=Fair; 3=Adequate; 4=Good; 5=Excellent

☐ **1. Area**

- ___ Housing
- ___ Schools
- ___ Recreation
- ___ Climate
- ___ Distance from Family
- ___ Practice Opportunities

☐ **2. Facilities**

- ___ Modern
- ___ Well Managed
- ___ Efficient
- ___ Good Staff

☐ **3. Faculty**

- ___ Experienced Clinicians
- ___ Educators
- ___ Humanistic

☐ **4. Residents**

- ___ Full Complement
- ___ Good Attitude
- ___ Graduates Board Certified

☐ **5. Benefits**

- ___ Salary
- ___ Health Insurance
- ___ Malpractice
- ___ CME/Professional Development
- ___ Moonlighting

☐ **6. Library/Technology**

- ___ Accessible
- ___ Full-time Librarian
- ___ Adequate Volumes
- ___ EHR/EMR

☐ **7. Curriculum**

- ___ Well Planned
- ___ Accredited Program
- ___ Variety of Electives
- ___ Conferences
- ___ International

☐ **8. Evaluation/Advancement**

- ___ Cognitive
- ___ Psychomotor
- ___ Feedback
- ___ Pyramid

☐ **9. Patients**

- ___ Adequate Numbers
- ___ All Socioeconomic Levels
- ___ Resident Responsibilities/Call
- ___ Back-up

☐ **10. Gut Feeling**

☐ **All Categories**

Comments

(A) Positive

(B) Negative

RESIDENCY PROGRAM EVALUATION GUIDE

Use this checklist to evaluate the residency programs in which you are interested.

Residency Program _____

Rating Scale: 1=Poor; 2=Fair; 3=Adequate; 4=Good; 5=Excellent.

On the basis of your needs, rate this residency program's:

Feature	Rating	Comments
Education		
Program philosophy		
Accreditation		
Overall curriculum		
Rotations/electives		
Rounds (educational vs. work)		
Conferences		
No. and variety of patients		
Hospital library		
Resident evaluations		
Board certification of graduates		
Attending Physicians/Teaching Faculty		
No. of full-time vs. part-time		
Research vs. teaching responsibilities		
Clinical vs. teaching skills		
Availability/approachability		
Preceptors in clinic		
Subspecialties represented		
Instruction in pt. counseling/education		
Hospital(s)		
Community or university hospital		
Staff physicians' support of program		
Availability of consultative services		
Other residency programs		
Type(s) of patients		
Hospital staff (nursing, lab, path, etc.)		
Current House Officers		
Number per year		
Medical schools of origin		
Personality		
Dependability		
Honesty		
Cooperativeness/get along together		
Compatibility/can I work with them?		

Feature	Rating	Comments
Work Load		
Average # pts./HO* (rotation, clinic)		
Supervision – senior HO, attending staff		
Call schedule		
Rounds		
Teaching/conference responsibility		
“Scut” work		
Time for conferences		
Clinic responsibilities		
Benefits		
Salary		
Professional dues		
Meals		
Insurance (malpractice, health, etc.)		
Vacation		
Paternity/Maternity/sick leave		
Outside conferences/books		
Moonlighting permitted		
Surrounding Community		
Size and type (urban/suburban/rural)		
Geographic location		
Climate and weather		
Environmental quality		
Socioeconomic/ethnic/religious diversity		
Safety (from crime)		
Cost of living (housing/food/utilities)		
Housing (availability and quality)		
Economy (industry/growth/recession)		
Employment opportunities (for significant other)		
Child care and public school systems		
Culture (music/drama/arts/movies)		
Entertainment—restaurant/area attractions		
Recreation—parks/sport/fitness facilities		
Program’s Strengths:		
Program’s Weaknesses:		

* House Officer

Provided by: Barberton Citizen's Hospital, Family Practice Residency Program, 155 Fifth Street, N.E., Barberton, Ohio 44203

PATIENT CENTERED MEDICAL HOME (PCMH)

QUESTIONS TO ASK RESIDENCY PROGRAMS

The Patient Centered Medical Home (PCMH) is the future of primary care in the United States. Through a personal physician, comprehensive care is coordinated and individualized to improve both the quality of care and access to cost-effective services. The following questions were designed to assist medical students who are interviewing with prospective residency programs to better understand the features of the PCMH and how individual programs have implemented the principles outlined.

Access to Care:

1. How does your program provide patient-centered enhanced access (e.g. evening or weekend hours, open-access (same day) scheduling, e-visits)?
2. How is the team concept practiced? What is the balance of open access to assurance of continuity with assigned provider? How does the PCMH concept carry over to the nursing home, hospital and other providers including mental health?

Electronic Health Records

1. What aspects of your medical home are electronic (e.g. medical records, order entry, eprescriptions)?
2. Does your practice use a Personal Health Record that allows patients to communicate their medical history from home to the healthcare team?

Population Management

1. Do you use patient registries to track your patients with chronic diseases and monitor for preventive services that are due?
2. Does your practice use reminder systems to let patients know when they are due for periodic testing (e.g. screening colonoscopy, PAP smear, mammogram) or office visits (e.g. annual exam)?

Team-Based Care

1. Who comprises your medical home team and how do they work together to deliver comprehensive care to your patients?
2. What services can non-physician members of the team (nurse practitioners, medical assistants, social workers, etc.) provide for

patients (e.g. diabetic education, asthma education)? How do you train them and ensure competency?

3. How are you preparing residents to be a leader of a team?

Continuous Quality Improvement

1. How do you monitor and work to improve quality of care provided in your medical home?
2. How do you monitor your ability to meet patient's expectations (e.g. patient satisfaction surveys)?
3. How are residents involved in helping to enhance practice quality and improve systems innovations? Is QA/PI activity an integral part of the organized learning experience, and is it integrated with training in EBM activities?

Care Coordination

1. How does your practice ensure care coordination with specialists and other providers?
2. How does your practice ensure seamless transitions between the hospital and outpatient environment?

Innovative Services

1. What procedural services are offered in your medical home (e.g. obstetrical ultrasound, treadmill stress testing, x-rays)?
2. How does your medical home provide group visits (e.g. prenatal group visit)? For what types of problems are group visits used and who participates?

FINDING THE RIGHT RESIDENCY PROGRAM FOR GLOBAL HEALTH EXPERIENCE

Questions to ask when you're evaluating a program.

Mission

- What is the goal of the international rotation?
- Describe the field experience (clinical activities, public health initiatives, community activities, patient education, or other activities.)

Funding

- What is the cost to the residents?
- What opportunities exist to seek additional funding for international rotations?
- Will I have professional liability insurance while participating?
- Will my employee benefits (health insurance, dental insurance, etc) continue while I am abroad?

Schedule

- How long are the rotations?
- What time of year do residents travel?
- Are certain years (PGY-1, PGY-2, PGY-3) prohibited from participation?

Location

- In what country (or countries) do the residents engage in international activities?
- Do the residents ever design their own global health experience?
- What policies and processes are in place to ensure resident safety during travel?

Contacts

- How many residents have participated in the past 2 years?
- Who are the faculty involved? What other international experiences have they had?
- Who do I contact to get more information?

Curriculum

- What are the didactics (lectures, reading, discussion, debriefing) of the rotation?
- Does the program accept medical students for trips?
- Does the program accept residents from other programs for trips?

Notes

Section 6

THE MATCH – WHAT IT IS AND HOW IT WORKS

WHAT IS THE MATCH?

You can find information about the National Resident Matching Program (NRMP) on the Web at <http://www.nrmp.org>. It contains information about registration, deadlines, etc. This site describes, in brief, the basic process through which the Match is conducted.

The NRMP provides a uniform system by which residency candidates simultaneously “match” to first- and second-year postgraduate training positions accredited by the ACGME.

It is uniform in that all the steps of the process are done in the same fashion and at the same time by all applicants and participating institutions. All students should enroll in the Match and are bound to abide by the terms of it. However, if a student is offered a position by an institution not in the Match, such as an osteopathic position or an unaccredited position, his or her dean of student affairs can withdraw the student before the Match deadline for changes. Keep in mind that if at least one of the institution’s residency programs participates in the Match, all programs in that institution must offer positions to U.S. allopathic medical school seniors only through the NRMP or another national matching program.

It is a violation of NRMP rules for either an applicant or a program to solicit information about how the other will rank them. If that information is solicited from you, you are under no obligation to, nor should you, provide it. It is not a violation for an applicant or a program to volunteer information about how one plans to rank the other. Any verbal indication of ranking is not binding, however, and the rank order list takes precedence. Students are advised not to rely on such verbal remarks when creating their rank order lists.

An applicant who certifies a rank order list enters into a binding commitment to accept the position if a match occurs. Failure to honor that commitment is a violation of the Match Participation Agreement signed during registration and triggers an investigation by

the NRMP. If the violation is confirmed, the applicant may be barred from programs in match-participating institutions for one year, and marked as a violator and/or barred from future matches for one to three years or permanently. In addition, the NRMP will notify the applicant’s medical school, the American Board of Medical Specialties, and other interested parties.

The Match is “nearly” all-inclusive because it lists almost all first-year positions in ACGME accredited training programs. Candidates for residency positions in Ophthalmology, Urology, and some Plastic Surgery programs will participate in other matches. However, these candidates must also participate in the NRMP in order to secure a preliminary position for each of those specialties. Furthermore, programs sponsored by some branches of the Uniformed Services do not participate in the NRMP.

The entire NRMP Match process is conducted via the Web using the Registration, Ranking, and Results System (R3). Users can access R3 through the NRMP Web site at www.nrmp.org. Applicants will pay their registration fee online with a credit card, enter their rank order list, and receive Match results via the Web.

The following section includes a detailed example from the NRMP, which illustrates how the Match works. In reading through this example, you will see how the Match accomplishes, in one day, what once took weeks of negotiation between residency applicants and hospitals when no NRMP existed. It is possible not to get the position you preferred; you may not match at all, but there are some simple guidelines that can help to ensure the best possible match for you.

- **Do not overestimate yourself.** Although you may think you will match at your top choice, you increase your chance of not matching by listing only one program.
- **Do not underestimate yourself.** Even if you do not think you have much of a chance

and if you really want to go somewhere in particular, go ahead and rank it first. The program may not get its top ten choices, and you might be number eleven on its list. It will not negatively influence your chances of matching to less competitive programs lower on your list. Remember, no one but you will know what rank you matched to.

- **Do not list programs that you do not want.**

You may end up at a program that you really did not want. Decide whether it is better to be unmatched than to be matched to a program that you don't want.

- **Remember that the order in which you rank programs is crucial to the Match process.** Upon casual consideration, one or more programs may seem fairly equivalent to you, but if you take the time to consider carefully, you may discover reasons you would rank one program over another. The Match computer is fair, but it is also indifferent to anything other than the rank order list provided. If you rank one program above another, it will put you in the first program if it can without stopping to consider that, after all, maybe geographic location is more important to you than a higher faculty to resident ratio.

- **Don't make your list too short.** On an average, unmatched students' lists were shorter than matched students' lists. Students selecting highly competitive specialties are advised to make longer lists.

These are just some of the guidelines that will help you as you begin the process of entering the Match. More information is posted to the NRMP website at www.nrmp.org in a report titled "Charting Outcomes in the Match." Keep an eye out for notices regarding information from the NRMP.

Not everyone will match to a position, and it is not true that only "bad" programs do not fill. A program may not fill if its rank list is at odds with the applicants who ranked it or if it is too short. There are likely to be several programs with unfilled positions that you would find desirable. In some cases, it may mean accepting a position in another specialty that you were considering as a second choice or were considering for the purpose of preparing you for the next year's Match. Your dean's office is prepared to counsel students who do not match. Applicants who do not match and programs that do not fill participate in the Match Week Supplemental Offer and Acceptance Program (SOAP). Detailed information about SOAP is available at www.nrmp.org.

HOW THE MATCHING ALGORITHM WORKS

Since 1998, the NRMP has used an applicant proposing algorithm in all its Matches. The following example illustrates how NRMP may best be used by all participants to prepare rank order lists and how the matching algorithm works.

Reprinted with permission of the National Resident Matching Program:

National Resident Matching Program

2450 N Street, NW

Washington DC 20037-1127

The NRMP matching algorithm uses the preferences expressed in the rank order lists submitted by applicants and programs to place individuals into positions. The process begins with an attempt to place an applicant into the program indicated as most preferred on that applicant's list. If the applicant cannot be matched to this first choice program, an attempt is then made to place the applicant into the second choice program, and so on, until the applicant obtains a tentative match, or all the applicant's choices have been exhausted.

An applicant can be tentatively matched to a program in this process if the program also ranks the applicant on its rank order list, and either:

- the program has an unfilled position. In this case, there is room in the program to make a tentative match between the applicant and program.
- the program does not have an unfilled position, but the applicant is more attractive to the program than another applicant who is already tentatively matched to the program. In this case, the applicant who is the least preferred current match in the program is removed from the program, to make room for a tentative match with the more preferred applicant.

Matches are "tentative" because an applicant who is matched to a program at one point in the matching process may be removed from the program at some later point, to make room for an applicant more preferred by the program, as described in the second case above. When an applicant is removed from a previously made tentative match, an attempt is made to re-match that applicant, starting from the top of his/her list. This process is carried out for all applicants, until each applicant has either been tentatively matched to the most preferred choice possible, or all choices submitted by the applicant have been exhausted. When all applicants have been considered, the match is complete and all tentative matches become final.

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Applicants' Rank Order Lists

Eight applicants are applying to four programs. After considering the relative desirability of each program, the applicants submit the following rank order lists to the NRMP.

Anderson	Brown	Chen	Davis	Eastman	Ford	Garcia	Hassan
1. City	1. City	1. City	1. Mercy	1. City	1. City	1. City	1. State
	2. Mercy	2. Mercy	2. City	2. Mercy	2. General	2. Mercy	2. City
			3.General	3. State	3. Mercy	3. State	3. Mercy
			4. State	4. General	4. State	4. General	4. General

Applicant Anderson makes only a single choice, City, because he believes, based on remarks he heard from the program director, that he would be ranked very highly at City, and he in turn assured the director that he would rank City number one. It is acceptable for programs to express a high level of interest in applicants to recruit them into their program, and for applicants to say that they prefer one program over others. **Such expressions, however, should not be considered as commitments.**

Applicant Brown ranks only the two programs that were on every applicant's list – Mercy and City. He is willing to go elsewhere but has ranked only those two programs because he believes he is very competitive. A member of Alpha Omega Alpha chosen in his junior year, he believes that he is a particularly desirable applicant. **Applicants should consider ranking all programs they are willing to attend to reduce the likelihood of not matching at all.**

Applicant Chen ranks City, which she prefers, and Mercy. Standing first in her class in her junior year, she knows that she is a desirable applicant, and she has been assured by the program director at Mercy that she will be ranked first. She thinks that Mercy will in fact rank her first, and so she reasons that there is no risk of her being left unmatched, even if she does not rank additional programs. **Unmatched applicants have shorter lists on the average than matched applicants. Short lists increase the likelihood of being unmatched.**

Applicant Ford would be very pleased to end up at State, where she had a very good clerkship, and believes they will rank her high on their list. Although, she does not think she has much of a chance she prefers City, General, or Mercy, so she ranks them higher and ranks State fourth. **This applicant is using NRMP to maximum advantage.**

Applicant Hassan is equally sure he will be able to obtain a position at State, but he too, would prefer the other programs. He ranks State first because he is afraid that State might fill its positions with others if he does not place it first on his list. **Applicants should rank programs in actual order of preference.** Their choices should not be influenced by speculation about whether a program will rank them high, low, or not at all. The position of a program on an applicant's rank order list will not affect that applicant's position on the program's rank order list, and therefore will not affect the program's preference for matching with that applicant as compared with any other applicants to the program. During the matching process, an applicant is placed in his/her most preferred program that ranks the applicant and does not fill all its positions with more preferred applicants. Therefore, rank number one should be the applicant's most preferred choice.

Applicants Davis, Eastman, and Garcia have interviewed at the same programs. Like the other applicants, they desire a position at City or Mercy and rank these programs either first or second, depending on preference. In addition to those desirable programs, those applicants also list State and General lower on their rank order lists. **They are using NRMP well.**

Programs' Rank Order Lists

Two positions are available at each program. The four programs, having determined their preferences for the eight applicants, also submit rank order lists to the NRMP.

Mercy	City	General	State
1. Chen	1. Garcia	1. Brown	1. Brown
2. Garcia	2. Hassan	2. Eastman	2. Eastman
	3. Eastman	3. Hassan	3. Anderson
	4. Anderson	4. Anderson	4. Chen
	5. Brown	5. Chen	5. Hassan
	6. Chen	6. Davis	6. Ford
	7. Davis	7. Garcia	7. Davis
	8. Ford		8. Garcia

The program director at Mercy Hospital ranks only two applicants, Chen and Garcia, for his two positions, although several more are acceptable. He has insisted that all applicants tell him exactly how they will rank his program and both of those applicants have assured him that they will rank his program very highly. He delights in telling his peers at national meetings that he never has to go far down his rank order list to fill his positions. The advantage of a matching program is that decisions about preferences can be made in private and without pressure. Both applicants and programs may try to influence decisions in their favor, but neither can force the other to make a binding commitment before the Match. **The final preferences of program directors and applicants as reflected on the submitted rank order lists will determine the placement of applicants.**

The program director at State feels that his program is not the most desirable to most of the applicants, but that he has a good chance of matching Ford and Hassan. Instead of ranking those two applicants at the top of his list, however, he ranks more desired applicants higher. He also ranks all of the acceptable applicants to his program. He is using the NRMP well.

The program directors at City and General have participated in the matching process before. They include all acceptable applicants on their rank order lists with the most preferred ranked high. Those program directors are not concerned about filling their available positions within the first two ranks. They prefer to try to match with the strongest, most desirable candidates. **They are using the NRMP to maximum advantage.**

Here's another example of the Matching Algorithm process at work, in tabular form.

APPLICANT	TRY TO PLACE IN	CURRENT PROGRAM STATUS	ACTION / RESULT (Shaded boxes indicate the final matches when the process is completed.)
ANDERSON	1. City	City has 2 unfilled positions.	Tentatively match Anderson with City.
BROWN	1. City	City has 1 unfilled position.	Tentatively match Brown with City.
CHEN	1. City	City is filled with more preferred applicants.	
	2. Mercy	Mercy has 2 unfilled positions.	Tentatively match Chen with Mercy.
DAVIS	1. Mercy	Mercy did not rank Davis.	
	2. City	City is filled with more preferred applicants.	
	3. General	General has 2 unfilled positions.	Tentatively match Davis with General.
EASTMAN	1. City	Although filled, City prefers Eastman to its least preferred current match (Brown).	Brown is removed from City to make room for Eastman. Tentatively match Eastman with City.
			Since Brown has just been removed from a previous tentative match, an attempt must now be made to re-match Brown.
BROWN	1. City	City is filled with more preferred applicants.	
	2. Mercy	Mercy did not rank Brown.	Brown remains unmatched.
FORD	1. City	City is filled with more preferred applicants.	
	2. General	General did not rank Ford.	
	3. Mercy	Mercy did not rank Ford.	
	4. State	State has 2 unfilled positions.	Tentatively match Ford with State.
GARCIA	1. City	Although filled, City prefers Garcia to its least preferred current match (Anderson).	Anderson is removed from City, to make room for Garcia. Tentatively match Garcia with City.
			Since Anderson has just been removed from a previous tentative match, an attempt must now be made to re-match Anderson.
ANDERSON	1. City	City is filled with more preferred applicants.	Anderson remains unmatched.
HASSAN	1. State	State has 1 unfilled position.	Tentatively match Hassan with State.

The process is now complete: each applicant has either been tentatively matched to the most preferred choice possible, or all choices submitted by the applicant have been exhausted. **Current tentative matches are now finalized.**

Note that the applicants Anderson and Brown went unmatched because they listed too few choices. Applicant Hassan could have matched at City had he ranked choices in order of preference.

Also note that Mercy, which ranked only two applicants, and General, which ranked seven out of eight, had unfilled positions. General could have matched with Ford, who ranked it #2, had Ford been on its rank order list.

Summary of Guidelines for the Preparation of Applicant Rank Order Lists

1. Applicants are advised to include on their rank order lists only those programs that represent their true preferences.
2. Programs should be ranked in sequence, according to the applicant's true preferences.
3. Factors to consider in determining the number of programs to rank include the competitiveness of the specialty, the competition for the specific programs being ranked, and the applicant's qualifications. In most instances, the issue is not the actual number of programs on the rank order list, but whether to add one or more additional programs to the list in order to reduce the likelihood of being unmatched.
4. Applicants are advised to rank all of the programs deemed acceptable, i.e., programs where they would be happy to undertake residency training. Conversely, if an applicant finds certain programs unacceptable and is not interested in accepting offers from those programs, the program(s) should not be included on the applicant's rank order list.

Updated 01/15/2012

Notes

Notes

Section 7

THE SOAP – SUPPLEMENTAL OFFER & ACCEPTANCE PROGRAM

TO SCRAMBLE OR TO SOAP?

The SCRAMBLE is the process used when unmatched residency applicants vie for unfilled residency positions after the Match. The NRMP offered the SOAP (Supplemental Offer and Acceptance Program) as a replacement for the managed “Scramble” program. The SOAP is scheduled to launch Match Week 2012. Some residency programs will participate in the Match and the SOAP, but others may still fill all of their positions outside of the Match.

SOAP stands for the Supplemental Offer and Acceptance Program and will go into effect during Match Week 2012. The SOAP will overhaul the Match week calendar, so all applicants, both unmatched and matched, will be effected by the changes.

Detailed information on the SOAP process can be found on the NRMP website: www.nrmp.org

Why a new process?

The NRMP cites a couple of issues as reasons to change the process. First, there has been heightened competition for positions, both in the main residency match, and in the Scramble. Over the past decade, the number of unfilled PGY-1 residency positions has declined from 2,228 in 2001 to 1,060 in 2010. Last year, nearly 13,000 applicants participated in the Scramble.

Second, there has been a perceived lack of transparency, oversight, and organization in the Scramble process. Until now, no one organization has had stewardship for the Scramble process. The NRMP hopes to provide organization and accountability to the new format.

What are the new changes?

1. The NRMP will take stewardship of the process
2. Unmatched applicant and unfilled residency program information will be released simultaneously
3. All participating applicants will be required to use ERAS

4. The NRMP’s web based system, R3, will now allow unfilled programs to submit preference lists for their empty spots
5. The SOAP will be covered by the Match Participation Agreement
6. Medical Schools and the ECFMG will be required to re-certify the status of their students. Ineligible students will not have access to the Dynamic List of Unfilled Programs.

The following principles will apply to ERAS users participating in SOAP during Match Week:

- The ERAS system will be synchronized to begin with the onset of the NRMP SOAP.
- Only applicants who are certified by the NRMP to participate in SOAP will be able to apply to NRMP unfilled programs using ERAS.
- Applicants who used ERAS during the regular season but did not participate in the NRMP may use ERAS during the SOAP period; however, they will have access only to programs that are not listed on the NRMP List of Unfilled Programs.
- Applicants applying via ERAS will have a limited number of applications they may transmit free of charge during the SOAP period.
- Before and after the SOAP period, the normal ERAS fees will apply.
- Programs may begin downloading applications as soon as the SOAP session opens.
- Non-NRMP participating programs that do not have unfilled positions will be encouraged to update their status in ERAS to indicate that they are “no longer accepting (NLA) applications”.

Eligible NRMP applicants:

- Must be able to enter GME on July 1 in the year of the Match
- Will be able to apply only to unfilled Match-participating programs during Match Week

- ✓ Access to the List of Unfilled Programs will be restricted by match status (preliminary or advanced)
- ✓ Must use ERAS and will be able to select only unfilled Match-participating programs
- ✓ Cannot use phone, fax, email, or other methods
- ✓ Cannot have another individual/entity contact programs on applicant's behalf
- ✓ Will be able to accept positions only through SOAP during Match Week
- Can apply to non-Match-participating programs after Match Week

Ineligible NRMP applicants:

- Cannot participate in SOAP
 - ✓ Cannot apply to Match-participating programs using ERAS, phone, fax, email, or other methods
 - ✓ Cannot have another individual/entity contact Match-participating programs on applicant's behalf
- Can apply to non-Match-participating programs during Match Week
 - ✓ Can use ERAS to select non-Match-participating programs
 - ✓ Can use phone, fax, email, or other methods
- Can apply to Match-participating programs after Match Week

Unfilled Programs:

- Must accept applications only through ERAS during Match Week
 - ✓ Cannot use phone, fax, email, or personal contacts
- Must fill positions using SOAP during Match Week
 - ✓ Cannot offer positions to ineligible applicants during Match Week
 - ✓ Cannot make offers outside SOAP during Match Week
 - ✓ Are not required to fill positions during Match Week
- Can add applicants to bottom of preference list

If an applicant rejects an offer or allows an offer to expire, no further offers will be made to that applicant by the same program. Once an applicant accepts an offer, the applicant will not be able to send additional applications via ERAS.

WHAT DOES THE MATCH WEEK TIMELINE LOOK LIKE NOW?

DAY	CURRENT SCHEDULE	PROPOSED SCHEDULE
Monday before Match Week		NRMP sends recertification request to Deans
Wednesday before Match Week		Noon <ul style="list-style-type: none"> • ECFMG data exchange completed • Dean's recertification deadline
Friday before Match Week		Noon <ul style="list-style-type: none"> • NRMP notifies all applicants, regardless of match status, whether they are eligible for the SOAP
Match Week: MONDAY	11:30 a.m. <ul style="list-style-type: none"> • Schools – receive unmatched Seniors Report • Schools – List of Unfilled Programs Noon <ul style="list-style-type: none"> • List of Unfilled Applications <p>Unmatched applicants begin sending applications to unfilled programs</p>	11:30 a.m. <ul style="list-style-type: none"> • Schools – receive unmatched Seniors Report Noon <ul style="list-style-type: none"> • Applicants – Did I Match? • Programs – Did I Fill? • List of Unfilled Positions Posted • Regional Match Statistics • ERAS Opens in SOAP Mode After Noon <ul style="list-style-type: none"> • SOAP Applicants start sending applications through ERAS • Program initiated telephone interviews with SOAP applicants begins (no offers allowed)
Match Week: TUESDAY	6:00 a.m. <ul style="list-style-type: none"> • Schools – Match Notification Letters • Schools – Electronic Match Results • Schools – Match Results (Web) • Schools – Applicant Choice by Specialty • Advanced Data Tables 2:00 p.m. <ul style="list-style-type: none"> • Programs – Roster of Matched Applicants 	All Day <ul style="list-style-type: none"> • Program initiated telephone interviews continue. • Programs begin entering pref lists in R3 system.

DAY	CURRENT SCHEDULE	PROPOSED SCHEDULE
Match Week: WEDNESDAY	<p>MATCH DAY!</p> <p>Noon</p> <ul style="list-style-type: none"> • School Ceremonies <p>1:00 p.m.</p> <ul style="list-style-type: none"> • Applicants – Where did I Match? 	<p>11:30 a.m.</p> <ul style="list-style-type: none"> • Program pref list deadline <p>Noon</p> <ul style="list-style-type: none"> • Electronic SOAP offers begin in the R3 system • SOAP offers are made every 3 hours <p>3:00 – 5:00 p.m.</p> <ul style="list-style-type: none"> • Last valid SOAP offers of the day <p>After Noon</p> <ul style="list-style-type: none"> • Program initiated telephone interviews continue • Programs can continue adding applicants to bottom of pref lists
Match Week: THURSDAY		<p>MATCH DAY!</p> <p>9:00 a.m.</p> <ul style="list-style-type: none"> • First SOAP offers of the day are made <p>Noon</p> <ul style="list-style-type: none"> • Second SOAP offers <p>3:00 – 5:00 p.m.</p> <ul style="list-style-type: none"> • Last valid SOAP offers of the day
Match Week FRIDAY		<p>MATCH DAY!</p> <p>9:00 a.m.</p> <ul style="list-style-type: none"> • First SOAP offers of the day are made <p>Noon</p> <ul style="list-style-type: none"> • Second SOAP offers • School Ceremonies <p>1:00 p.m.</p> <ul style="list-style-type: none"> • Applicants: Where di I Match? <p>3:00 – 5:00 p.m.</p> <ul style="list-style-type: none"> • Last valid SOAP offers of the day <p>5:00 p.m.</p> <ul style="list-style-type: none"> • ERAS SOAP mode ends
Monday after Match Week	<p>Noon</p> <ul style="list-style-type: none"> • Match Outcomes for all Programs • Match Results by Ranked Applicant 	<p>Noon</p> <ul style="list-style-type: none"> • Match Outcomes for all Programs • Match Results by Ranked Applicant

Notes

Section 8

RESOURCES

RESOURCES AND REFERENCES

The following is a selection of books, articles and Web references that appear in the preceding text.

Books of Interest

- *Directory of Family Medicine Residency Programs*, American Academy of Family Physicians, annual publication. Also available on the Web at <http://www.aafp.org/residencies/>
- *Graduate Medical Education Directory (GMED)*, American Medical Association.
- *How To Choose A Medical Specialty*, Anita D. Taylor, Philadelphia: W.B. Saunders Co., 4th Edition, 2003.
- *Iserson's Getting Into A Residency: A Guide for Medical Students*, Kenneth V. Iserson, Galen Press, Ltd., 7th Edition, 2003.
- *Resumes and Personal Statements for Health Professionals*, Galen Press, Ltd., 2nd Edition, 2001.
- *The Ultimate Guide to Choosing a Medical Specialty*, Brian S. Freeman, M.D., McGraw-Hill Publication, 2004.

Journals Of Interest

- *American Family Physician*, American Academy of Family Physicians.
- *msJAMA Online*, American Medical Association Medical Student Section.
- *The New Physician*, American Medical Student Association.
- *Journal For Minority Medical Students*, Spectrum Unlimited.

Online Residency Directories of Interest

- AMSA's Online Residency Directory hosted by the American Medical Student Association at <http://www.amsa.org/resource/resdir/reshome.cfm>
- Directory of Family Medicine Residency Programs hosted by the American Academy of Family Physicians at <http://www.aafp.org/residencies/>
- Fellowship and Residency Electronic Interactive Database (FREIDA Online) hosted by the American Medical Association at <http://www.ama-assn.org/ama/pub/category/2997.html>
- Find a Resident Web site hosted by the Association of American Medical College is an on-line service to assist programs with filling unanticipated vacancies and to help applicants identify residency and fellowship opportunities that are not available via ERAS and the NRMP. Print your web browser to www.aamc.org/findaresident
- Interactive Internal Medicine Residency Database hosted by ACP-ASIM at www.acponline.org/residency

Other Web Sites of Interest

- AAMC Careers in Medicine at <http://www.aamc.org/students/cim/>
- Electronic Residency Application Service (ERAS) at <http://www.aamc.org/students/eras/>
- National Residency Matching Program (NRMP) at <http://www.nrmp.org>
- San Francisco Match site at <http://www.sfmarch.org>
- Virtual FMIG — <http://fmignet.aafp.org/residency.xml>
- AMA Medical Student Section — <http://amaMedStudent.org>

The following is a list of other important organizations, which are referred to in the preceding text.

American Academy of Family Physicians

11400 Tomahawk Creek Parkway
Leawood, KS 66211
(800) 274-2237

Web: <http://www.aafp.org>

American Medical Association

515 N. State Street
Chicago, IL 60610

Web: <http://www.ama-assn.org>

Association of American Medical Colleges/ Electronic Residency Application Service

2450 N Street, NW
Washington, DC 20037-1126
(202) 828-0400

Web: <http://www.aamc.org/eras>

National Resident Matching Program

2450 N Street, NW
Washington, DC 20037-1127
(202) 828-0566

Web: <http://www.nrmp.org>

*Strolling Through the Match Evaluation Form on the reverse,
Please tear off and send to the AAFP. Address on the back.*

***Strolling Through the Match* Evaluation Form**

All users of *Strolling Through the Match*, student, faculty or otherwise, are invited to give us their feedback regarding the usefulness of this material.

1. Please indicate the overall usefulness of each of the major sections of this guide:

	Not Useful		Somewhat Useful		Very Useful
A. Choosing a Specialty	1	2	3	4	5
B. The Time Line	1	2	3	4	5
C. Preparation	1	2	3	4	5
D. Selecting a Program	1	2	3	4	5
E. The Interview Process	1	2	3	4	5
F. The Match	1	2	3	4	5

2. Were there any portions which you found particularly valuable? (Please indicate section by the letters A – F as specified above.)

3. Were there any portions which you thought were weak and need improvement?

4. How have you used these materials? (Check all that apply)

- _____ as a student
- _____ as a faculty advisor
- _____ as a lecturer (please specify group or meeting:)
- _____ other (please specify)

5. Are there any other resources or references you would suggest adding to the guide? Please list.

6. Any other comments?

Thank you for taking the time to give us feedback. Please return this form to:

**Division of Medical Education, Resident and Student Activities Department,
American Academy of Family Physicians, 11400 Tomahawk Creek Parkway,
Leawood, Kansas 66211**

Notes

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About the American Academy of Family Physicians

Founded in 1947, the AAFP represents 100,300 physicians and medical students nationwide. It is the only medical society devoted solely to primary care.

Approximately one in four of all office visits are made to family physicians. That is 228 million office visits each year — nearly 84 million more than the next largest medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care.

To learn more about the specialty of family medicine, the AAFP's positions on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit aafp.org/media. For information about health care, health conditions, and wellness, please visit the AAFP's award-winning consumer website, familydoctor.org.

Explore Family Medicine through Virtual FMIG

www.fmignet.aafp.org



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

VIRTUAL **FMIG**
FAMILY MEDICINE INTEREST GROUP

ADVOCACY

FACT SHEET

19% of all Americans are **Medically Disenfranchised** and have inadequate access to a primary care physician.

Family Medicine — Despite numerous studies showing primary care helps prevent illness and death, primary care is still undervalued in the United States. The AAFP advocates for a primary care-based system with incentives to help medical students choose family medicine.

46 million Americans, including 9 million children, are living without health care coverage.

Coverage for All — The AAFP actively supports legislation that enables all people to access health care, regardless of income. However, the AAFP also recognizes that proper health care can only be possible with an adequate number of primary care physicians.

Upon implementation of a **Patient-Centered Medical Home**, Community Care of North Carolina saved **\$150 million** over two years with asthma and diabetes patients, while increasing quality outcomes.

Patient-Centered Medical Home (PCMH) — The Patient-Centered Medical Home allows comprehensive primary care for everyone by creating partnerships between patients, their physicians, and the patient's family. The PCMH helps each patient have an ongoing relationship with a personal physician.

Health Care Reform —
a top priority for both the **Federal and State Governments.**

Advocacy — Through the AAFP's grassroots efforts, FamMedPAC (the AAFP's political action committee), and through our staff presence in Washington D.C., the Academy is able to legislatively support patients as well as family physicians.



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Explore FAMILY MEDICINE

ADVOCACY

AND YOU

How to Advocate at the National Level

Attend the National Conference of Family Medicine Residents and Medical Students — aafp.org/nc

Learn to write resolutions, participate in the Student Congress, and watch recommendations become AAFP Policy.

Participate in the Family Medicine Congressional Conference

Learn how to lobby, and then go do it. Students can attend this conference in Washington D.C. for free.

Become a Key Contact — aafp.org/grassroots/getinvolved

Build a strong on-going relationship with key congressional members in positions important to the policy goals and objectives of the AAFP.

Contribute to FamMedPac: The AAFP's federal political action committee — aafp.org/pac

Its purpose is to help elect candidates to the U.S. Congress who support AAFP's legislative goals and objectives.

Speak Out for Family Medicine

Write a letter, email, or fax your Congressman or Editor of your local paper telling them how medical students are changing the health care system.

Understand the Patient-Centered Medical Home (PCMH) — aafp.org/pcmh

The PCMH is at the center of the health care reform debate and crucial to the future of health care in America. Not surprisingly, it's built on the foundation of family medicine—continuous, comprehensive, whole-person care.

Connect for Reform — aafp.org/connect4reform

Take your front-row seat in Washington. Join the AAFP Connect for Reform campaign to stay informed about developments on Capitol Hill that affect you. Discover opportunities to get involved.

Join the Student Interest Discussion Forum — fmignet.aafp.org/discuss

Connect with other medical students and engage in dialogue about health care policy issues.

How to Advocate at the Local Level

Join your FMIG and organize an advocacy event — fmignet.aafp.org/getinvolved

Invite a Legislator to speak at your school, start a letter writing campaign on a significant issue, or partner with the community to engage in change.

Advocate for your patients

Identify a community health need and work with local leaders to make changes on behalf of your patients.

Create a new Student Advocate Position with your state chapter

Encourage your state chapter to include students and residents in Hill visits. Organize a student legislative liaison to report on state activities to FMIGs.

Join the State Health Policy Listserv — aafp.org/myacademy

Get up to date information about state level policy changes.

Explore

*FAMILY
MEDICINE*

... where every facet of medicine
is yours to discover

www.aafp.org/explore

FAMILY Medicine Explore NEW Worlds

The Family Medicine model of care highlights:

- patient focused
- electronic health record
- quality and safety measurements
- multidisciplinary team
- organized chronic disease management

What is Family Medicine?

The backbone of the American health care system, family physicians conduct more office visits each year than any other medical specialty. Family physicians provide comprehensive care that includes prevention, acute intervention, chronic disease management, end-of-life care, and coordination of care. In addition, family physicians provide the majority of care for America's underserved and rural populations.

In the increasingly fragmented world of health care where many medical specialties limit their practice to a particular organ, disease, age or sex, family physicians are dedicated to treating the whole person across the full spectrum of ages. The heart of Family Medicine is an ongoing, personal patient-physician relationship focused on integrated care.

As the providers of more than 90 percent of the health care that patients need throughout their lives, family physicians advocate for and establish long-term relationships with patients and their family members.

Preventive Care Benefits

- Longer life spans and fewer deaths due to heart and lung disease
- Fewer cases of and deaths due to colon and cervical cancer
- Less ER and hospital use
- Reduced health disparities

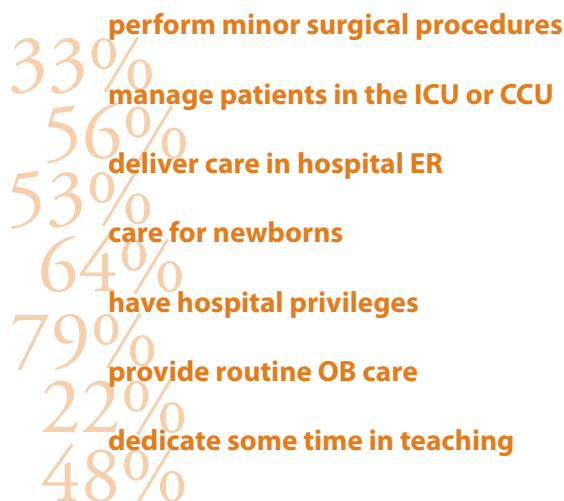
EXPERIENCE Family Medicine's Model of CARE

The family medicine model of care aims to reintegrate and personalize health care for patients. This model provides a patient-centered personal medical home through which they can receive services within the context of a continuing relationship with their physician.

Rewards of Practice

- Integrating patient care
- Communicating with patients, listening to their health secrets and fears, and educating them regarding their health status and care options
- Generating relevant new knowledge through practice-based research
- Networking with other practices to provide the best care for their patients
- Providing effective practice administration to support patient care
- Making a difference in the lives of patients, their families, and their communities
- Working in multidisciplinary teams to achieve better health outcomes
- Using new information technology to deliver and improve care

By the NUMBERS...



An increase of one family physician per 10,000 people would decrease mortality by 6%.



www.aafp.org/explore

FAMILY Physicians The Right Stuff

Family Physicians' Attributes Include:

- whole-person orientation
- relationship-focused
- natural command of complexity
- talent for humanizing health care

Building Strong Relationships

Family physicians have a unique influence on their patients' lives. Serving as a partner to maintain well-being over time, a family physician empowers patients with information and guidance needed to maintain health. In addition, family physicians provide long-term behavioral change interventions and develop ongoing communication with patients and families.

Explore Family Medicine Training

During three-years of residency training, family physicians cover child care, maternity care, primary mental health, surgical procedures, community medicine, and supportive care including end-of-life care. Combined residencies (internal medicine, emergency medicine, or psychiatry) and fellowships (sports medicine, obstetrics, sleep medicine, and more) are available. With more than 400 family medicine residencies in community-based, medical school-based, military, inner-city, urban, suburban, and rural settings, the choice is yours.

Family physicians are trained to care for complex diseases, including asthma, congestive heart failure, coronary heart disease, depression and anxiety, diabetes, hypertension, multiple sclerosis, and Parkinson's. During training, family physicians learn to:

- consider all of the influences on a patient's health
- know and understand people's limitations, problems, and personal beliefs when deciding on a treatment
- be appropriate and efficient in proposing therapies and interventions
- develop rewarding relationships with patients

Family medicine residents care for their continuity patients in a supervised group practice at the residency clinical offices. Hospital training occurs during each year of family medicine residency training. Family medicine residents work and learn throughout the hospital — in the emergency department, labor and delivery department, the operating room, intensive care units, and on numerous general and specialty wards.

Family Medicine Procedures: Options for possible care

- Colposcopy/LEEP
- Colonoscopy
- Endoscopy
- Maternity care procedures
- Skin biopsies
- Suturing lacerations
- Ultrasound imaging
- Vasectomy
- And more...

Lifestyle

Today's family physician is a tech savvy, small business owner, who still has time to attend his or her kids' soccer games, plus:

- 50 hours per week in patient-related activities
- 5 weeks for vacation/CME
- 25% increase in income projected for family practices that use new technologies and new care models such as chronic disease management

Practice Options

- Solo practice
- Multispecialty group practice
- Careers in public health, government, residency or medical school faculty, or politics
- Research
- Hospitals
- International medicine
- Frontier or wilderness medicine
- Rural, urban and suburban practices
- Emergency care
- Variety in call schedule options
- And others...

Distribution

The geographical spread of family physicians across the United States more closely matches the geographic spread of the general population than any other specialty.

While **79%** of the U.S. population is in urban areas,
71% of family physicians are in urban areas.

While **21%** of the U.S. population is in rural areas,
29% of family physicians are in rural areas





AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

www.aafp.org/explore

Responses to Medical Students' Frequently Asked Questions About Family Medicine

AMY L. MCGAHA, MD, *American Academy of Family Physicians, Leawood, Kansas*

ELIZABETH GARRETT, MD, MSPH, *University of Missouri–Columbia School of Medicine, Columbia, Missouri*

ANN C. JOBE, MD, MSN, *Educational Commission for Foreign Medical Graduates, Philadelphia, Pennsylvania*

PETER NALIN, MD, *Indiana University School of Medicine, Indianapolis, Indiana*

WARREN P. NEWTON, MD, MPH, *University of North Carolina at Chapel Hill School of Medicine, Chapel Hill, North Carolina*

PERRY A. PUGNO, MD, MPH, *American Academy of Family Physicians, Leawood, Kansas*

NORMAN B. KAHN, JR., MD, *American Academy of Family Physicians, Leawood, Kansas*

This article provides answers to many questions medical students ask about the specialty of family medicine. It was developed through the collaborative efforts of several family medicine organizations, including the American Academy of Family Physicians, the Society of Teachers of Family Medicine, the Association of Family Medicine Residency Directors, and the Association of Departments of Family Medicine. The article discusses the benefits of primary care and family medicine, the education and training of family physicians, the scope of medical practice in the specialty, and issues related to lifestyle and medical student debt. (*Am Fam Physician* 2007;76:99-106. Copyright © 2007 American Academy of Family Physicians.)

► See related editorial on page 36.

When considering their future specialty, many medical students have questions about family medicine. This article provides answers to the most common of these questions. It is the fifth update of a previous article and was developed through the collaborative efforts of several family medicine organizations, including the American Academy of Family Physicians (AAFP), the Society of Teachers of Family Medicine (STFM), the Association of Family Medicine Residency Directors (AFMRD), and the Association of Departments of Family Medicine (ADFM).¹

Physicians specializing in family medicine deliver primary care in the United States and around the world. Fifty percent of the care provided in the outpatient setting is delivered by primary care physicians (*Figure 1*).² Students who choose a career in family medicine become part of the foundation of the health care system, establishing long-term relationships with patients and their family members and providing more than 90 percent of the health care that patients need throughout their lives.³ It is this close relationship between physician and patient over time that both patients and physicians say they value most.⁴

Why is family medicine/primary care important?

The lack of a primary care focus in the U.S. health care system has resulted in poorer health outcomes for Americans compared with persons in other industrialized countries.⁵ In a comparison with other developed countries, the United States ranked lowest in primary care functions and in health care outcomes despite having the highest level of health care spending.⁶⁻⁹

Several decades of accumulated evidence shows that a health system that focuses on primary care is more effective, more efficient, and more equitable. These benefits are demonstrated by reduced all-cause mortality rates,¹⁰ less frequent use of emergency departments and hospitals,^{11,12} better preventive care,¹³⁻¹⁵ improved detection of and reduction in mortality from several cancers,¹⁶⁻¹⁸ less frequent testing and medication use, better patient satisfaction,¹⁹⁻²⁰ and a reduction in health disparities.^{4,21,22}

What makes family medicine unique?

Family medicine's cornerstone is an ongoing, personal patient–physician relationship. Whereas other specialties are limited to a

The Ecology of Health Care

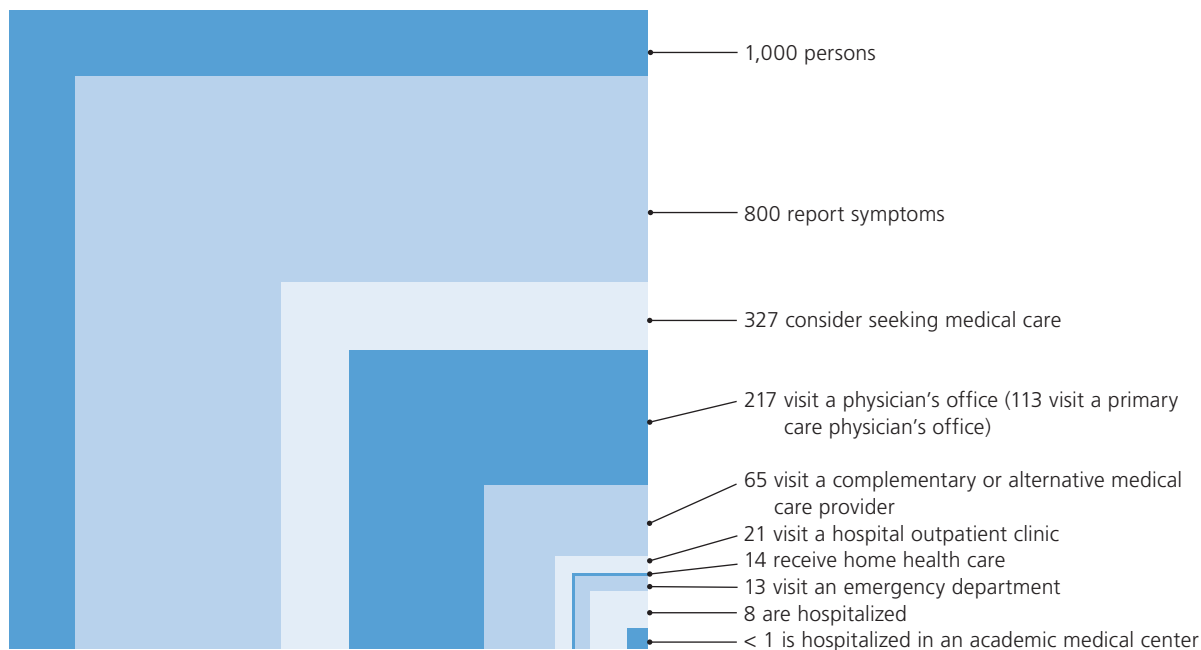


Figure 1. The ecology of health care.

NOTE: The group in each box is not necessarily a subset of the preceding box. Some persons may be counted in more than one box.

Reprinted with permission from Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med* 2001;344:2022.

particular organ system, technology, disease, age, or sex, family medicine integrates care for each person. Family physicians' unique contributions to health care access stem from the breadth of their training and adaptability of their work, combined with a sense of social responsibility.

Patients value a physician who listens to them, who takes time to explain things to them, and who is able to effectively coordinate and integrate their care.⁴ Since its inception, family medicine has been grounded in the core values of a continuing relationship between patient and physician, and the provision of comprehensive care that includes prevention, acute intervention, chronic disease management, end-of-life care, and coordination of care throughout the health care delivery system.

What career opportunities will be available to me as a family physician?

Training in family medicine gives a physician the flexibility to adapt to different practice environments.²³ Family physicians work in multispecialty group practices and in solo practice settings. More than 80 percent of family physicians choose to have hospital

privileges.²³ Some limit their practice to an emergency department or work exclusively within the hospital. Many family physicians provide care in a combination of settings. They may work full-time or part-time. They may work within a managed care plan or a group for a set salary, or they may run their own business. Family physicians may pursue careers in public health, government, academia, and political office.

Is family medicine training good preparation for a career in international medicine, frontier or wilderness medicine, or emergency care?

Family physicians receive broad medical training that prepares them to care for patients in a wide range of settings. With good training, family physicians are competent to practice in a large hospital with many health care resources or in an international or wilderness environment where resources may be scarce.

Americans in rural areas depend on family physicians to deliver care in the communities and remote locations in which they live and work. The geographic distribution of family physicians is similar to that

of the U.S. population: 24 percent of the population lives in communities of fewer than 10,000 persons, and 23 percent of family physicians practice in such communities.²⁴ Without family physicians, many U.S. counties would be health professional shortage areas (HPSAs)—geographic areas, population groups, or medical facilities that the U.S. Department of Health and Human Services determines to be served by too few health professionals of particular specialties. If all family physicians were withdrawn, 58 percent of U.S. counties would become primary care HPSAs (PCHPSAs) (Figure 2); in contrast, only 8 percent of counties would be PCHPSAs if all general internists, pediatricians, and obstetrician-gynecologists were withdrawn.²⁵ Among physicians working in U.S. emergency departments, approximately 30 percent completed family medicine residencies.²⁶

What is involved in family medicine training, and what are combined residencies?

Family medicine residencies, like pediatric and internal medicine residencies, last three years. Hospital training occurs during each year of family medicine residency training. Family medicine residents work and learn throughout the hospital, in the emergency department, labor and delivery department, the operating room, and intensive care units, and on numerous general and specialty wards.

Family medicine residents care for their continuity patients in a supervised group practice at the residency clinical offices. Residents are assigned a panel of patients and provide continuous care for those patients throughout their training, including inpatient care, maternity care, and hospice care when necessary. Family medicine leads the primary care disciplines in outpatient continuity clinical hours.²⁷ Behavioral science training, counseling, and community outreach are all features of family medicine residency training.

There are more than 460 family medicine residencies in the United States. Combined residencies are hybrids of two residencies

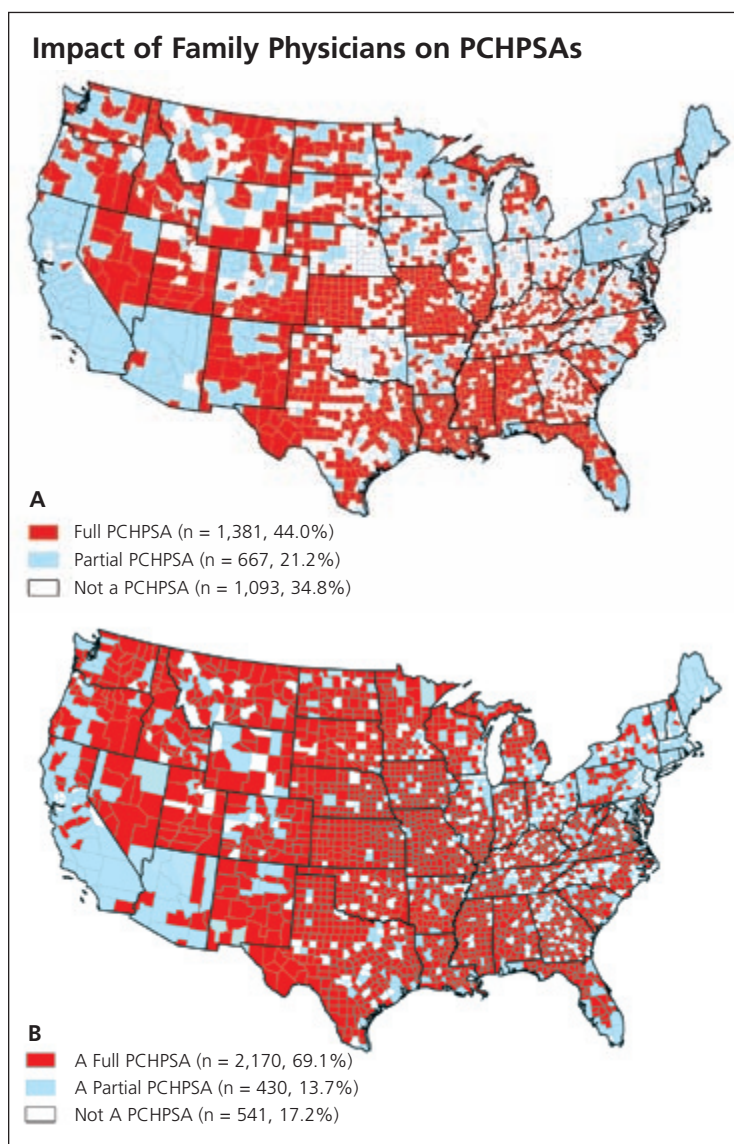


Figure 2. (A) U.S. PCHPSAs by county, 2006. (B) U.S. PCHPSAs by county after withdrawal of family physicians. (PCHPSA = primary care health professional shortage area.)

(e.g., family medicine and psychiatry, family medicine and internal medicine).

Students often ask about “med-peds” programs and how they differ from family medicine training. Med-peds programs combine three-year residencies in internal medicine and pediatrics into one four-year program, with most med-peds physicians pursuing subspecialty fellowships. The Accreditation Council for Graduate Medical Education does not accredit combined programs as one

program but maintains the specialty distinction of the two programs. Graduates of combined programs are eligible to take two certification examinations, according to the expectations of each of the two specialties.

What is the difference between university-based and community-based residency programs?

Traditionally, in university-based programs family medicine residents train alongside residents in other specialties. Residents in university-based programs regularly have the opportunity to teach medical students. Community-based residency programs traditionally are in smaller hospital settings, where family medicine may be the only residency and student contact may be less than that in university-based programs.

Some students think family medicine residents in community-based programs are first in line for admissions and procedures and have more opportunities for supervisory

roles, whereas family medicine residents at a university gain exposure to the latest innovations and research discoveries and have more opportunities to develop as teachers. However, these broad characterizations are often inaccurate. Students

should decide which overall context will be the best for them, considering factors such as setting (rural or urban), program size, region, patient populations served, and procedural training offered. Most advisers recommend that students look at both university- and community-based programs in their research. Valuable information, tips, and strategies for the residency application process can be found on the Virtual Family Medicine Interest Group (FMIG) Web site (<http://fmignet.aafp.org>).

What types of advanced training or fellowships are available to family medicine graduates?

Family physicians have a variety of advanced training options open to them after completing their residency training. Common reasons for pursuing advanced training include

the desire to obtain research training, preparation to enter academics, and gaining more in-depth clinical skills to offer in one's practice. A fellowship directory produced by the AAFP in cooperation with STFM is available at <http://www.aafp.org/fellowships>. This valuable resource lists fellowships by content area as well as by state.

Fellowship programs in geriatrics, sports, and adolescent medicine lead to a certificate of added qualifications (CAQ) from the American Board of Family Medicine (ABFM). Successful CAQ candidates must be certified in family medicine. More information on CAQs can be found on the ABFM Web site (<http://www.theabfm.org>). Other fellowships that are popular among graduates of family medicine residencies include faculty development, maternity care, preventive care, research, and palliative care. Many of the fellowship programs listed in the directory are customized arrangements made between an institution and the trainee.

How do family physicians keep current with medical advances in the care of children, adolescents, adults, older adults, men, women, and pregnant women?

Family medicine was the first specialty to require continuing medical education (CME) of its members. Family physicians must earn a minimum of 50 CME credits annually; this training enables them to continue to learn and keep up with medical advances throughout their careers. CME is required for board certification in family medicine, for hospital and practice privileges in many locales, and for membership in the AAFP.

CME is delivered to family physicians through live courses (for new knowledge and for adding procedures to practice) and published materials (print, audio, and video). *American Family Physician* has the widest circulation of any primary care journal and is available to student members of the AAFP. Family physicians are increasingly obtaining CME through the Internet, where all types of CME are delivered.

A dramatic shift in CME for physicians was created by family medicine in 2002.

Family medicine was the first specialty to require continuing medical education of its members.

Evidence-based CME (EB CME) uses internationally accepted sources of medical evidence as the basis for key practice recommendations (<http://www.aafp.org/online/en/home/cme/cmea/ebcme.html>). EB CME is the basis for two revolutionary formats of CME, jointly developed under the leadership of the AAFP and the American Medical Association (AMA): point-of-care CME and performance improvement CME. These new forms of CME promise not only to improve patient outcomes through evidence-based medicine, but also to prepare family physicians for the measures insurers and payers will require.

What is the scope of practice for family physicians?

The goal of the Future of Family Medicine project (<http://www.futurefamilymed.org/index.html>), a joint effort of the Family Medicine Working Party, was to develop a strategy to transform and renew the specialty of family medicine to meet the needs of patients and society in a changing environment. One of the lessons learned from this project was that patients want the availability of a broad array of services.⁴

Sixty percent of family physicians care for newborns. About 15 percent of visits to a typical practice are from children. At the other end of the age continuum, more than 90 percent of family physicians treat Medicare patients.²⁸

Most family physicians have a component of their practice outside the office. A large majority (82 percent) have hospital privileges, and more than 40 percent manage patients in the intensive care unit or coronary care unit. Of family physicians' patients who are admitted to the hospital, most are treated by family physicians, their partners, or a call group. Other family physicians choose to turn over the care of their hospitalized patients to full-time hospitalist physicians, many of whom are family physicians. In addition to patients treated in the clinic or hospital settings, typical family physicians also supervise the care their patients receive while in nursing homes, home health care, or hospices.

In some communities, family physicians include a significant amount of maternity care in their practice: 23 percent of residency-trained family physicians deliver babies, with an average of 2.4 deliveries each month.²⁸ Additional information about family physicians' practices can be found at <http://www.aafp.org/online/en/home/aboutus/specialty/facts.html>.

What elements of family medicine are most rewarding?

Personal rewards of practicing family medicine include the satisfaction of establishing continuous, long-term relationships with patients and partnering with patients in the management of their health. Family physicians gain great satisfaction from the rewards intrinsic to patient care, including a personal connection with and gratitude from patients (*Table 1*⁴).

Family physicians enjoy the challenge of making the right diagnosis from what may seem to be a series of unrelated and often vague symptoms. Family physicians are highly valued for their diagnostic and

Table 1. Rewards of Practice for Family Physicians

A role in integrating patient care
Communicating with patients, listening to their secrets and fears, and educating them regarding their health status and care options
Generating relevant new knowledge through practice-based research
Intellectual stimulation from the variety of scope of family medicine
Networking with other practices to provide the best care for their patients
The opportunity to provide effective practice administration to support patient care
The opportunity to make a difference in the lives of patients, their families, and their communities
The opportunity to work in multidisciplinary teams to achieve better health outcomes
Using new information technology to deliver and improve care

Information from reference 4.

patient-advocacy skills. Providing care for patients throughout their lives helps ensure they get appropriate screening and preventive services well before they have established disease. Family physicians take pride in their ability to help patients understand the varied and subtle ways in which a person's health affects the family and community.³

What types of procedures are typically performed by family physicians?

In addition to routine inpatient and outpatient care, family physicians perform a wide range of procedures. Most family physicians (82 percent) perform skin and nail procedures; 35 percent regularly perform colonoscopy; and 35 percent perform flexible sigmoidoscopy.²⁹ Family physicians receive training in a variety of procedures, including joint injections, paracentesis, thoracentesis, intubation and advanced life support, ultrasonography, stress testing, colonoscopy, esophagogastroduodenoscopy, vasectomy, tubal ligation, cervical cancer treatment (e.g., loop electrosurgical excision procedure [LEEP], cryotherapy), and pulmonary function testing. Family physicians also receive training in maternity care, which includes prenatal management, intrapartum procedures, delivery, and management of maternal and neonatal complications.

What is the typical medical education debt of family medicine residency graduates, and what types of loan repayment and consolidation options are available to family physicians?

Medical education debt has increased significantly in the past 20 years. According to the Association of American Medical Colleges (AAMC), the median level of debt of medical school graduates in the class of 2005 was \$120,000, including undergraduate loans.³⁰ The median level of debt of family medicine residency graduates in 2004 was \$145,300, according to the AAFP.²³

Medical education financial aid differs from financial aid for any other professional group of students. There is a wide and at times confusing array of options: government (direct) loans, Federal Family

Education Loan Program loans, internship/residency forbearance, economic hardship deferments, scholarships, service commitment scholarships, graduated repayment plans, and extended repayment plans.

Students and residents should consider the impact of debt and seek out the best information and advice. The most important source of information is a good-quality loan exit interview, which is required at all U.S. allopathic and osteopathic schools for all students with a federal loan. Financial aid officers have become extremely important resources for medical students, and their expertise should be sought out whenever questions arise.

The AAMC has several useful Web sites for medical students, including <http://www.aamc.org/stloan> and <http://www.aamc.org/students> (Table 2). The AMA has information regarding medical student debt in the medical student section of its Web site (<http://www.ama-assn.org/ama/pub/category/5010.html>). The FMIG Web site is also a good resource. The AAFP Debt Management Guide can be found at <http://fmignet.aafp.org/x24.xml>.

Table 2. Online Resources

Advanced training

<http://www.aafp.org/fellowships>
<http://www.aafp.org/online/en/home/cme/cmea/ebcme.html>
<http://www.theabfm.org>

Debt

<http://www.aamc.org/stloan>
<http://www.ama-assn.org/ama/pub/category/5010.html>
<http://fmignet.aafp.org/x24.xml>

Family medicine

<http://www.aafp.org/online/en/home/aboutus/specialty/facts.html>
<http://www.futurefamilymed.org/index.html>
<http://fmignet.aafp.org/familymedicine.xml>

Health information technology

<http://www.centerforhit.org>

Residency application

<http://fmignet.aafp.org/residency.xml>

There are several ways to manage loans, and students need to be well informed.

Are family physicians in demand?

The demand for family physicians in the United States has continued to rise since 2003. The Merritt, Hawkins and Associates' 2006 Review of Physician Recruiting Incentives shows a steady increase in demand for family physicians, with family medicine being the second most recruited specialty.³¹ Job openings continue to be strong for family physicians. In a recent national survey of hospitals that were recruiting physicians, 45 percent were recruiting family physicians, whereas 32 percent were recruiting internists, 21 percent obstetricians, and 20 percent anesthesiologists.³¹ Similarly, classified advertisements for family physicians increased 12 percent from 2003 to 2004, and 20 percent from 2004 to 2005.³² Demand is expected to remain strong as the U.S. population grows and the need for medical care increases with the increasing prevalence of chronic disease.³³ The mean salary of family physicians in 2004 was \$143,600.²³

What is the future of family medicine?

The Future of Family Medicine report identified what patients want and expect from their primary, personal physician: first, establishment of a continuing relationship; and second, provision of a personal medical home to which they can bring any health problem and where they can partner with their physician to maximize their wellness.⁴

Based on the findings of the Future of Family Medicine report, a new model of family medicine is being demonstrated; this began in 2006. The family medicine model of care aims to reintegrate and personalize health care for patients, who are increasingly frustrated with the fragmented and complex health care system. This model provides patients with a personal medical home through which they can expect to receive comprehensive health care within the context of a continuing relationship with their physician.

Electronic health records are becoming the central nervous system of the family

medicine practice, reducing medical errors and improving quality of care. The AAFP's Center for Health Information Technology provides family physicians with tools and resources to develop health information technology in their practices (<http://www.centerforhit.org>).

In the future, family medicine will provide a model of care that is fully patient-centered, including innovations such as open-access scheduling, group visits, and improved electronic communication between patients and practice staff to ensure that patients get what they need, when they need it.

Figure 2 was prepared by the Robert Graham Center, Policy Studies in Family Medicine and Primary Care, Washington, D.C., with data from the Health Resources and Services Administration (August 3, 2006).

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Global Health

FACT SHEET

1,010,000,000

Number of hits on Google generated when searching for “International Health” (June 20, 2007).

\$7,831,388,467

Global Health funding provided by the Bill & Melinda Gates Foundation since its inception through March 2007.

69%

Percentage of students attending the 2005 National Conference of Family Medicine Residents and Medical Students who stated that the presence of an international opportunity during residency would influence their decision to choose a particular residency program.

308

Number of family medicine residency programs offering international health opportunities.

www.aafp.org/residencies

90%

Percentage of residency programs who will pay at least one month's salary for a resident participating in an international rotation.

300

Number of organizations profiled in “A Practical Guide to Global Health Service” (author Ed O’Neil).

This guide offers tips on how to focus on direct action and how to safely and effectively get engaged in medical volunteering.

1991

Year Physicians With Heart was founded. Family physicians have visited Russia, Ukraine, Kyrgyzstan, Kazakhstan, Georgia, Uzbekistan, Azerbaijan, Moldova, and Tajikistan through this AAFP and AAFP Foundation humanitarian project.

- Family medicine’s **broad scope** of training uniquely prepares physicians to practice medicine in a variety of settings, with specific consideration of public health and community resources.
- U.S. family physicians work closely with WONCA and are active in **numerous global health organizations** such as GHEC and through the State Department in Embassy postings. Family physicians are **developers and leaders** of many mission organizations—both faith-based and secular—and in academic departments with a focus on global health.



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Explore

Family Medicine

Finding the RIGHT international rotation.

Questions to ask when you're evaluating a program.

MISSION

- What is the goal of the international rotation?
- Describe the field experience (clinical activities, public health initiatives, community activities, patient education, or other activities).

FUNDING

- What is the cost to the residents?
- What opportunities exist to seek additional funding for international rotations?
- Will I have professional liability insurance while participating?
- Will my employee benefits (health insurance, dental insurance, etc) continue while I am abroad?

SCHEDULE

- How long are the rotations?
- What time of year do residents travel?
- Are certain years (PGY-1, PGY-2, PGY-3) prohibited from participation?

LOCATION

- In what country (or countries) do the residents engage in international activities?
- Do the residents ever design their own global health experience?
- What policies and processes are in place to ensure resident safety during travel?

CONTACTS

- How many residents have participated in the past 2 years?
- Who are the faculty involved? What other international experiences have they had?
- Who do I contact to get more information?

CURRICULUM

- What are the didactics (lectures, reading, discussion, debriefing) of the rotation?
- Does the program accept medical students for trips?
- Does the program accept residents from other programs for trips?

Email: international@aafp.org

Medical STUDENT eGuide

The Web is a big place.
Let us show you around.

1 Interested in family medicine?

Learn more about the specialty of family medicine on the AAFP's student website.

fmignet.aafp.org

Find the full range of family medicine fellowships.

aafp.org/fellowships

2 Thriving in med school?

Identify third- and fourth-year rotations to boost your clinical experience.

aafp.org/clerkships

Get tips on limiting cost and managing debt before, during, and after medical school.

fmignet.aafp.org/debtmanagement

Access free online Board Review questions.

aafp.org/boardreview/questions

3 Are you connected?

See what's going on in your area and beyond.

fmignet.aafp.org/calendar

Connect with FMIG Network Regional Coordinators and join listservs for your school's region.

fmignet.aafp.org/connect

Read what's happening in medical student news.

fmignet.aafp.org/hottopics.xml



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graph TD; Step4[4 Searching for your residency?] --> Step5[5 Thinking globally?]; Step5 --> Step6[6 Heard about National Conference?]; Step6 --> Join[Join the AAFP. It's FREE for students!];
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4

Searching for your residency?

Get the facts with a student's guide to *Strolling Through the Match*.

fmignet.aafp.org/strolling

Search U.S. family medicine residency programs, with information on faculty, staff, size, and salaries.

aafp.org/residencies

5

Thinking globally?

Find international health care opportunities, volunteer opportunities, and resources for funding of international elective rotations.

fmignet.aafp.org/international

Search for residency programs with international components.

aafp.org/international/residencies

Watch and learn about family medicine and global health.

fmignet.aafp.org/globalhealthvideo

6

Heard about National Conference?

It's an awesome, can't-miss event for medical students and family medicine residents. Experience skills workshops, lectures, networking, and a lot of fun. And scholarships are available!

fmignet.aafp.org/fmignc

Join the AAFP. It's FREE for students!

Become a member of the American Academy of Family Physicians and get:

- Online access to *American Family Physician*
- Support through local AAFP chapters
- Discounts on AAFP products and services
- And more...

aafp.org/join

Questions?

Email fmignet@aafp.org

Patient-Centered Medical Home

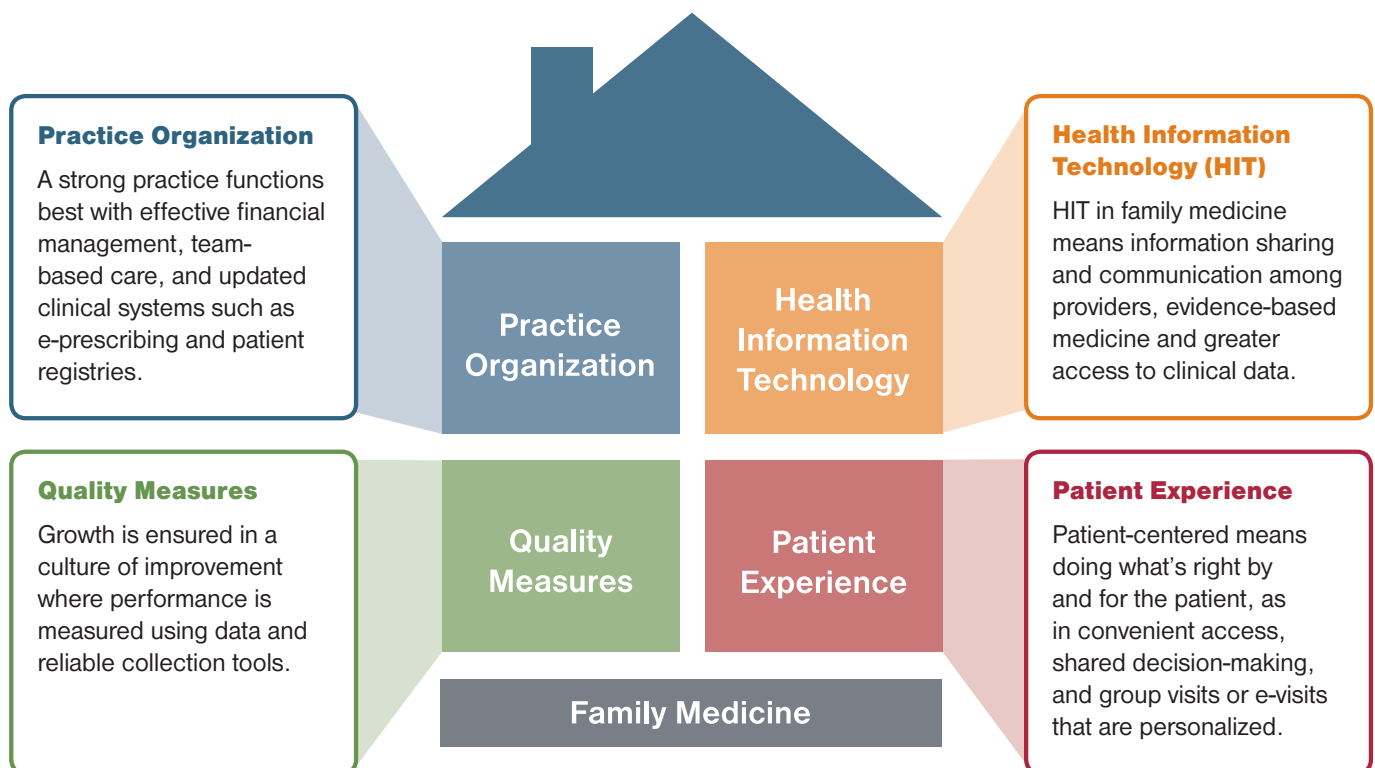
Current state of the U.S. health care system

- Ranked 37th in quality by the World Health Organization
- Spends more per capita than any other nation in the world
- 20% to 30% of patient tests and procedures are unnecessary and not beneficial

PCMH: The Future of Primary Care

The Patient Centered Medical Home (PCMH) is the future of primary care in the United States. Through a personal family physician, comprehensive care is coordinated and individualized to deliver better health outcomes such as:

- ↓ mortality and morbidity
- ↓ medication use
- ↓ per capita expenditures
- ↑ patient satisfaction
- ↑ greater equity in health care



Patient-Centered Medical Home

Questions for Medical Students to Ask Family Medicine Residency Programs

The following questions were designed to assist medical students who are interviewing with prospective residency programs to better understand the features of the PCMH and how individual programs have implemented the principles outlined.

Access to Care:

1. How does your program provide patient-centered enhanced access (e.g. evening or weekend hours, open-access (same day) scheduling, e-visits)?
2. How is the team concept practiced? What is the balance of open access to assurance of continuity with assigned provider? How does the PCMH concept carry over to the nursing home, hospital and other providers including mental health?

Electronic Health Records

1. What aspects of your medical home are electronic (e.g. medical records, order entry, eprescriptions)?
2. Does your practice use a Personal Health Record that allows patients to communicate their medical history from home to the healthcare team?

Population Management

1. Do you use patient registries to track your patients with chronic diseases and monitor for preventive services that are due?
2. Does your practice use reminder systems to let patients know when they are due for periodic testing (e.g. screening colonoscopy, PAP smear, mammogram) or office visits (e.g. annual exam)?

Team-Based Care

1. Who comprises your medical home team and how do they work together to deliver comprehensive care to your patients?
2. What services can non-physician members of the team (nurse practitioners, medical assistants, social workers, etc.) provide for patients (e.g. diabetic education, asthma education)? How do you train them and ensure competency?
3. How are you preparing residents to be a leader of a team?

Continuous Quality Improvement

1. How do you monitor and work to improve quality of care provided in your medical home?
2. How do you monitor your ability to meet patient's expectations (e.g. patient satisfaction surveys)?
3. How are residents involved in helping to enhance practice quality and improve systems innovations? Is CQI activity an integral part of the organized learning experience, and is it integrated with training in EBM activities?

Care Coordination

1. How does your practice ensure care coordination with specialists and other providers?
2. How does your practice ensure seamless transitions between the hospital and outpatient environment?

Innovative Services

1. What procedural services are offered in your medical home (e.g. obstetrical ultrasound, treadmill stress testing, x-rays)?
2. How does your medical home provide group visits (e.g. prenatal group visit)? For what types of problems are group visits used and who participates?



American Family Physician

A peer reviewed journal of the American Academy of Family Physicians

ADDITIONAL CLINICAL RESOURCES

Immunization Schedules

- 2010 Childhood Immunization schedule
- 2010 Adolescent Immunization schedule
- 2010 Adult Immunization Schedule

EBM articles: Here is the link to the EBM series:

<http://www.aafp.org/online/en/home/publications/journals/afp/ebmtoolkit/articlesresources.html>

In AFP, it's in the EBM toolkit (left navigation), and then "Articles and resources".

- Links to USPSTF Recommendations <http://www.ahrq.gov/clinic/uspstf/uspsttopics.htm>
- www.needymeds.org,
- www.advocacyoncall.org

American Family Physician

A peer reviewed journal of the American Academy of Family Physicians

AAFP RESOURCES

Student Membership:

AAFP Student members have access to cutting edge AAFP members-only clinical information and resources, such as exclusive online access to *American Family Physician* (recently voted the #2 clinical journal among primary care physicians), *AAFP News Now*, Family Medicine Board Review questions and answers, member discounts, mentoring programs, scholarships, and local chapter resources. Find out why more than 17,000 medical students are already AAFP members at www.aafp.org/join.

Virtual FMIG Website:

Virtual FMIG provides medical students with information that is relevant at each point in their medical education from admission to graduation. The mission of the AAFP's student Web site is to increase awareness of and advocate for the specialty of family medicine, while also serving as a credible resource for information relevant to students at each point in their medical education, from admission to graduation. <http://fmignet.aafp.org>

Videos:

Physician Profile Videos: <http://fmignet.aafp.org/online/fmig/index/resources/profiles.html>

Global Health Video: <http://fmignet.aafp.org/online/fmig/index/resources/fmigvideos/globalhealth.html>

Advocacy Videos: <http://fmignet.aafp.org/online/fmig/index/resources/fmigvideos.html>

Debt Management Resources:

FMIG Debt Management: <http://fmignet.aafp.org/online/fmig/index/medical-school/studentdebt.html>

EVALUATION

Link to the online user evaluation:
<http://www.aafp.org/surv6/cflash10.htm>

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- [Additional Resources](#)
- [Adult Immunization Schedule 2012](#)
- [Childhood Immunization Schedules 2012](#)

ADDITIONAL CLINICAL RESOURCES

- Immunization Schedules
- EBM articles: Here is the link to the EBM series:

<http://www.aafp.org/online/en/home/publications/journals/afp/ebmtoolkit/articlesresources.html>

In AFP, it's in the EBM toolkit (left navigation), and then "Articles and resources".

-
- Links to USPSTF Recommendations
<http://www.ahrq.gov/clinic/uspstf/uspsttopics.htm>
- www.needymeds.org,
- www.advocacyoncall.org

AAFP RESOURCES

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AAFP Student members have access to cutting edge AAFP members-only clinical information and resources, such as exclusive online access to *American Family Physician* (recently voted the #2 clinical journal among primary care physicians), *AAFP News Now*, Family Medicine Board Review questions and answers, member discounts, mentoring programs, scholarships, and local chapter resources. Find out why more than 17,000 medical students are already AAFP members at www.aafp.org/join.

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Recommended Adult Immunization Schedule — United States, 2012

Each year, the Advisory Committee on Immunization Practices (ACIP) reviews the recommended adult immunization schedule to ensure that the schedule reflects current recommendations for licensed vaccines. In October 2011, ACIP approved the adult immunization schedule for 2012, which includes several changes from 2011. A footnote directing readers to links for the full ACIP vaccine recommendations and where to find additional information on specific vaccine recommendations for travelers is now included. In addition, a **Table** summarizing precautions and contraindications was added. This table is based on the corresponding table in the 12th edition of *Epidemiology and Prevention of Vaccine-Preventable Diseases* and is included to provide ready access to key safety information for adult vaccine providers (1).

Changes to the footnote for tetanus, diphtheria, and acellular pertussis (Tdap) and tetanus, diphtheria (Td) vaccines were made to update recommendations. Tdap vaccine is recommended specifically for persons who are close contacts of infants younger than 12 months of age (e.g., parents, grandparents, and child-care providers) and who have not received Tdap previously. Before 2011, vaccination postpartum was preferred for women who had not had a previous adult Tdap dose. However, in 2011, ACIP recommended pregnant women preferentially receive Tdap vaccination during later pregnancy (>20 weeks gestation). Other adults who are close contacts of children younger than 12 months of age continue to be recommended to receive a one-time dose of Tdap vaccine.

Updates to the footnotes and figures also were made for human papillomavirus (HPV) and hepatitis B vaccines based on recommendations made at the October 2011 ACIP meeting. The HPV vaccine recommendation has been updated to include routine vaccination of

males 11–12 years of age, with catch-up vaccination recommended for males 13–21 years of age. HPV vaccine also is recommended for previously unvaccinated males 22–26 years of age who are immunocompromised, or who test positive for human immunodeficiency virus (HIV) infection, or who have sex with men.

ACIP also voted in October 2011 to recommend hepatitis B vaccine for adults <60 years of age who have diabetes, as soon as possible after diabetes is diagnosed. In addition, hepatitis B vaccination is recommended at the discretion of the treating clinician for adults with diabetes who are 60 years or older based on a patient's likely need for assisted blood glucose monitoring, likelihood of acquiring hepatitis B, and likelihood of immune response to vaccination.

A notation was included for zoster vaccine to acknowledge that the vaccine was recently approved by the Food and Drug Administration (FDA) for administration to persons 50 years of age and older; however, ACIP continues to recommend that vaccination begin at age 60 years. The influenza vaccine footnote was revised to specify age indications for the different licensed formulations of trivalent inactivated influenza vaccine (TIV). The footnote for the measles, mumps, rubella (MMR) vaccine was simplified to focus only on routine use of this vaccine in adults; information on use of the vaccine for outbreak control was removed. Readers are referred to the ACIP MMR recommendations and to the ACIP recommendations for the immunization of health-care personnel regarding the use of MMR vaccine in outbreak settings. Additional information on the use of quadrivalent meningococcal conjugate vaccine (MCV4) and meningococcal polysaccharide vaccine (MPSV4) for specific age and risk groups was added. Minor clarifications also were made to the footnotes for HPV vaccine, varicella vaccine, and pneumococcal polysaccharide vaccine (PPSV).

Additional information is available as follows: 1) immunization schedule (in English and Spanish) at <http://www.cdc.gov/vaccines/recs/schedules/adult-schedule.htm>; 2) information regarding adult vaccination at <http://www.cdc.gov/vaccines/default.htm>; 3) ACIP statements for specific vaccines at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>; and 4) reporting of adverse events at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967. This schedule also has been presented to the American Academy of Family Physicians, the American College of Physicians, the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives for approval and publication in their respective journals.

The recommended adult immunization schedule has been approved by the Advisory Committee on Immunization Practices, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American College of Nurse-Midwives.

Suggested citation: Centers for Disease Control and Prevention. Recommended adult immunization schedule—United States, 2012. *MMWR* 2012;61(4).

Footnote changes for 2012

- A new footnote (1), “Additional information,” has been added to the beginning of the footnotes. This footnote provides links to the full ACIP vaccine recommendations and information on travel requirements that might have been referred to previously in subsequent footnotes.
- The “Influenza vaccination” footnote (2) was revised to clarify that all persons aged 6 months and older can receive TIV and that health-care personnel (HCP) who care for persons requiring a protected environment should receive TIV. HCP younger than 50 years who do not have a contraindication may receive either the live attenuated influenza vaccine or TIV. In addition, age indications for two recently licensed formulations of TIV were included. The link to additional information regarding influenza vaccination has been removed because a link now is provided in footnote 1.
- The “Human papillomavirus (HPV) vaccination” footnote (5) now clarifies that although HPV vaccination is not specifically recommended for HCP, HCP should receive the HPV vaccine if they are in the recommended age group. This footnote also was changed to reflect the recommendation of the quadrivalent human papillomavirus (HPV4) vaccine for males at age 11 or 12 years and catch-up vaccination for males 13 through 21 years of age. Males 22 through 26 years of age may be vaccinated with HPV4 vaccine.
- The “Zoster vaccination” footnote (6) now indicates that while zoster vaccination is not specifically recommended for HCP, HCP should receive the vaccine if they are in the recommended age group. This footnote also acknowledges that the vaccine is FDA-approved for use in persons 50 years and older; however, ACIP continues to recommend that vaccination begin at age 60 years.
- The link in the “Measles, mumps, rubella (MMR) vaccination” footnote (7) that directs the reader to more information about evidence of immunity has been removed. In addition, the information about the use of MMR vaccine in outbreak settings has been removed. Readers are referred to the ACIP MMR recommendations and to the ACIP recommendations for the immunization of health-care personnel regarding the use of MMR vaccine in outbreak settings.
- The “Pneumococcal polysaccharide (PPSV) vaccination” footnote (8) has been revised to include additional examples of functional and anatomic asplenia. Language is included for persons with asymptomatic or symptomatic HIV infection and persons undergoing cancer chemotherapy or who are on other immunosuppressive therapy.
- The “Revaccination with PPSV” footnote (9) has been revised to clarify guidance for those aged 65 years and older who had been vaccinated with PPSV23 before age 65 and for whom at least 5 years has passed since their previous dose.
- The “Meningococcal vaccination” footnote (10) has been revised to include military recruits in the group recommended to receive a single dose of meningococcal vaccine. The language about college

students has been clarified to indicate that first-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday. Language regarding travel to sub-Saharan Africa and travel to Mecca has been removed, and readers are referred to the footnote on information about vaccines for travelers (1).

- The “Hepatitis B vaccination” footnote (12) has been revised to include persons with diabetes younger than 60 years old and persons 60 years and older based on need for assisted blood glucose monitoring.
- Finally, all footnotes were changed from paragraph form to a bulleted format to provide for greater ease in use of the recommendations.

Figures

- For Figure 1, the bar for Tdap/Td for persons 65 years and older has been changed to a yellow and purple hashed bar to indicate that persons in this age group should receive 1 dose of Tdap if they are a close contact of an infant younger than 12 months of age. However, other persons 65 and older who are not close contacts of infants may receive either Tdap or Td.
- The 19–26 years age group was divided into 19–21 years and 22–26 years age groups. The HPV vaccine bar was split into separate bars for females and males. The recommendation for all males 19–21 years to receive HPV is indicated with a yellow bar, and a purple bar is used for 22–26 year old males to indicate that the vaccine is only for certain high-risk groups.
- For Figure 2, a new column was added for men who have sex with men (MSM) to note in the figure that MSM is an indication for HPV, hepatitis A, and hepatitis B vaccines.
- In addition, the diabetes indication was moved to the same column as chronic kidney disease to accommodate the new recommendation for hepatitis B vaccination of persons with diabetes.
- Because pregnant women not previously vaccinated with Tdap are now preferentially recommended for vaccination with Tdap during later pregnancy (>20 weeks gestation), the yellow bar has been extended across all risk groups.
- The HPV vaccine bar was separated into a bar for females and one for males. The bar for females is unchanged from the previous year except that the bar was extended to include HCP to clarify that HCP who are in the recommended age group for receipt of HPV vaccine are recommended for vaccination.
- Lastly, the HPV vaccine bar for males was added and indicates that all males through age 26 should be vaccinated if they are immunocompromised, have HIV, or are MSM. However, the age indication is through age 21 for males with or without these risk factors.

Reference

1. CDC. Epidemiology and prevention of vaccine-preventable diseases. Atkinson W, Wolfe S, Hamborsky J, eds. 12th ed. Washington DC: Public Health Foundation; 2011.

FIGURE 1. Recommended adult immunization schedule, by vaccine and age group¹ — United States, 2012

VACCINE ▼	AGE GROUP ►	19–21 years	22–26 years	27–49 years	50–59 years	60–64 years	≥65 years
Influenza ^{2,*}		1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) ^{3,*}		Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 years					
Varicella ^{4,*}		2 doses					
Human papillomavirus (HPV) ^{5,*} Female		3 doses					
Human papillomavirus (HPV) ^{5,*} Male		3 doses					
Zoster ⁶						1 dose	
Measles, mumps, rubella (MMR) ^{7,*}		1 or 2 doses			1 dose		
Pneumococcal (polysaccharide) ^{8,9}		1 or 2 doses					1 dose
Meningococcal ^{10,*}		1 or more doses					
Hepatitis A ^{11,*}		2 doses					
Hepatitis B ^{12,*}		3 doses					

* Covered by the Vaccine Injury Compensation Program









	For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection		Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)		Tdap recommended for ≥65 if contact with <12 month old child. Either Td or Tdap can be used if no infant contact		No recommendation
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FIGURE 2. Vaccines that might be indicated for adults, based on medical and other indications¹ — United States, 2012

INDICATION►		Immunocompromising conditions (excluding human immunodeficiency virus [HIV]) ^{4,6,7,14}	HIV infection ^{4, 7, 13, 14} CD4 ⁺ T lymphocyte count				Asplenia ¹³ (including elective splenectomy and persistent complement component deficiencies)		Diabetes, kidney failure, end-stage renal disease, receipt of hemodialysis	
VACCINE▼	Pregnancy		<200 cells/ μL	≥200 cells/μL	Men who have sex with men (MSM)	Heart disease, chronic lung disease, chronic alcoholism		Chronic liver disease		Health-care personnel
Influenza ^{2,*}		1 dose TIV annually			1 dose TIV or LAIV annually	1 dose TIV annually				1 dose TIV or LAIV annually
Tetanus, diphtheria, pertussis (Td/Tdap) ^{3,*}		Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 years								
Varicella ^{4,*}		Contraindicated		2 doses						
Human papillomavirus (HPV) ^{5,*} Female		3 doses through age 26 years				3 doses through age 26 years				
Human papillomavirus (HPV) ^{5,*} Male		3 doses through age 26 years				3 doses through age 21 years				
Zoster ⁶		Contraindicated			1 dose					
Measles, mumps, rubella ^{7,*}		Contraindicated		1 or 2 doses						
Pneumococcal (polysaccharide) ^{8,9}		1 or 2 doses								
Meningococcal ^{10,*}		1 or more doses								
Hepatitis A ^{11,*}					2 doses					
Hepatitis B ^{12,*}					3 doses					

* Covered by the Vaccine Injury Compensation Program

	For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection		Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)		Contraindicated		No recommendation
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NOTE: The above recommendations must be read along with the footnotes on pages 4–5 of this schedule.

1. Additional information

- Advisory Committee on Immunization Practices (ACIP) vaccine recommendations and additional information are available at: <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.
- Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) available at <http://www.wnc.cdc.gov/travel/page/vaccinations.htm>.

2. Influenza vaccination

- Annual vaccination against influenza is recommended for all persons 6 months of age and older.
- Persons 6 months of age and older, including pregnant women, can receive the trivalent inactivated vaccine (TIV).
- Healthy, nonpregnant adults younger than age 50 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or TIV. Health-care personnel who care for severely immunocompromised persons (i.e., those who require care in a protected environment) should receive TIV rather than LAIV. Other persons should receive TIV.
- The intramuscular or intradermal administered TIV are options for adults aged 18–64 years.
- Adults aged 65 years and older can receive the standard dose TIV or the high-dose TIV (Fluzone High-Dose).

3. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

- Administer a one-time dose of Tdap to adults younger than age 65 years who have not received Tdap previously or for whom vaccine status is unknown to replace one of the 10-year Td boosters.
- Tdap is specifically recommended for the following persons:
 - pregnant women more than 20 weeks' gestation,
 - adults, regardless of age, who are close contacts of infants younger than age 12 months (e.g., parents, grandparents, or child care providers), and
 - health-care personnel.
- Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-containing vaccine.
- Pregnant women not vaccinated during pregnancy should receive Tdap immediately postpartum.
- Adults 65 years and older may receive Tdap.
- Adults with unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series. Tdap should be substituted for a single dose of Td in the vaccination series with Tdap preferred as the first dose.
- For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second.
- If incompletely vaccinated (i.e., less than 3 doses), administer remaining doses. Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (See footnote 1).

4. Varicella vaccination

- All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
- Special consideration for vaccination should be given to those who
 - have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or
 - are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
- Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.
- Evidence of immunity to varicella in adults includes any of the following:
 - documentation of 2 doses of varicella vaccine at least 4 weeks apart;
 - U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity);
 - history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or having an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link to a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease);
 - history of herpes zoster based on diagnosis or verification of herpes zoster by a health-care provider; or
 - laboratory evidence of immunity or laboratory confirmation of disease.

5. Human papillomavirus (HPV) vaccination

- Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4).
- For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at 11 or 12 years of age, and for those 13 through 26 years of age, if not previously vaccinated.
- For males, HPV4 is recommended in a 3-dose series for routine vaccination at 11 or 12 years of age, and for those 13 through 21 years of age, if not previously vaccinated. Males 22 through 26 years of age may be vaccinated.

- HPV vaccines are not live vaccines and can be administered to persons who are immunocompromised as a result of infection (including HIV infection), disease, or medications. Vaccine is recommended for immunocompromised persons through age 26 years who did not get any or all doses when they were younger. The immune response and vaccine efficacy might be less than that in immunocompetent persons.
- Men who have sex with men (MSM) might especially benefit from vaccination to prevent condyloma and anal cancer. HPV4 is recommended for MSM through age 26 years who did not get any or all doses when they were younger.
- Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, persons who are sexually active should still be vaccinated consistent with age-based recommendations. HPV vaccine can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test.
- A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose (at least 24 weeks after the first dose).
- Although HPV vaccination is not specifically recommended for health-care personnel (HCP) based on their occupation, HCP should receive the HPV vaccine if they are in the recommended age group.

6. Zoster vaccination

- A single dose of zoster vaccine is recommended for adults 60 years of age and older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the Food and Drug Administration (FDA) for use among and can be administered to persons 50 years and older, ACIP recommends that vaccination begins at 60 years of age.
- Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.
- Although zoster vaccination is not specifically recommended for health-care personnel (HCP), HCP should receive the vaccine if they are in the recommended age group.

7. Measles, mumps, rubella (MMR) vaccination

- Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, laboratory evidence of immunity to each of the three diseases, or documentation of provider-diagnosed measles or mumps disease. For rubella, documentation of provider-diagnosed disease is not considered acceptable evidence of immunity.

Measles component:

- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
 - are students in postsecondary educational institutions;
 - work in a health-care facility; or
 - plan to travel internationally.
- Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type from 1963 to 1967 should be revaccinated with 2 doses of MMR vaccine.

Mumps component:

- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
 - are students in postsecondary educational institutions;
 - work in a health-care facility; or
 - plan to travel internationally.
- Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health-care facility) should be considered for revaccination with 2 doses of MMR vaccine.

Rubella component:

- For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

Health-care personnel born before 1957:

- For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider routinely vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.

8. Pneumococcal polysaccharide (PPSV) vaccination

- Vaccinate all persons with the following indications:
 - age 65 years and older without a history of PPSV vaccination;
 - adults younger than 65 years with chronic lung disease (including chronic obstructive pulmonary disease, emphysema, and asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver disease (including cirrhosis); alcoholism; cochlear implants; cerebrospinal fluid leaks; immunocompromising conditions; and functional or anatomic asplenia (e.g., sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]);
 - residents of nursing homes or long-term care facilities; and
 - adults who smoke cigarettes.
- Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after their diagnosis.

- When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. Vaccination during chemotherapy or radiation therapy should be avoided.
 - Routine use of PPSV is not recommended for American Indians/Alaska Natives or other persons younger than 65 years of age unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives who are living in areas where the risk for invasive pneumococcal disease is increased.
- 9. Revaccination with PPSV**
- One-time revaccination 5 years after the first dose is recommended for persons 19 through 64 years of age with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions.
 - Persons who received PPSV before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose.
 - No further doses are needed for persons vaccinated with PPSV at or after age 65 years.
- 10. Meningococcal vaccination**
- Administer 2 doses of meningococcal conjugate vaccine quadrivalent (MCV4) at least 2 months apart to adults with functional asplenia or persistent complement component deficiencies.
 - HIV-infected persons who are vaccinated should also receive 2 doses.
 - Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of *Neisseria meningitidis*, military recruits, and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
 - First-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday.
 - MCV4 is preferred for adults with any of the preceding indications who are 55 years old and younger; meningococcal polysaccharide vaccine (MPSV4) is preferred for adults 56 years and older.
 - Revaccination with MCV4 every 5 years is recommended for adults previously vaccinated with MCV4 or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia or persistent complement component deficiencies).
- 11. Hepatitis A vaccination**
- Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
 - men who have sex with men and persons who use injection drugs;
 - persons working with HAV-infected primates or with HAV in a research laboratory setting;
 - persons with chronic liver disease and persons who receive clotting factor concentrates;
 - persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A; and
 - unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. (See footnote 1 for more information on travel recommendations). The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
- Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30 followed by a booster dose at month 12.
- 12. Hepatitis B vaccination**
- Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
 - sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men;
 - health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids;
 - persons with diabetes younger than 60 years as soon as feasible after diagnosis; persons with diabetes who are 60 years or older at the discretion of the treating clinician based on increased need for assisted blood glucose monitoring in long-term care facilities, likelihood of acquiring hepatitis B infection, its complications or chronic sequelae, and likelihood of immune response to vaccination;
 - persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease;
 - household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
 - all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.
 - Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.
 - Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 µg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 µg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.
- 13. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used**
- 1 dose of Hib vaccine should be considered for persons who have sickle cell disease, leukemia, or HIV infection, or who have anatomic or functional asplenia if they have not previously received Hib vaccine.
- 14. Immunocompromising conditions**
- Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and influenza [inactivated influenza vaccine]), and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2012. For all vaccines being recommended on the adult immunization schedule: a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/pubs/acip-list.htm>).

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at <http://www.hrsa.gov/vaccinecompensation> or by telephone, 800-338-2382. Information about filing a claim for vaccine injury is available through the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination also is available at <http://www.cdc.gov/vaccines> or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. to 8:00 p.m., Monday through Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

TABLE. Contraindications and precautions to commonly used vaccines in adults^{1*†}

Vaccine	Contraindications	Precautions
Influenza, injectable trivalent (TIV)	Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine or to a vaccine component, including egg protein.	Moderate or severe acute illness with or without fever. History of Guillain-Barré syndrome (GBS) within 6 weeks of previous influenza vaccination.
Influenza, live attenuated (LAIV) ²	Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine or to a vaccine component, including egg protein. Immune suppression. Certain chronic medical conditions such as asthma, diabetes, heart or kidney disease. ³ Pregnancy.	Moderate or severe acute illness with or without fever. History of GBS within 6 weeks of previous influenza vaccination. Receipt of specific antivirals (i.e., amantadine, rimantadine, zanamivir, or oseltamivir) 48 hours before vaccination. Avoid use of these antiviral drugs for 14 days after vaccination.
Tetanus, diphtheria, pertussis (Tdap); tetanus, diphtheria (Td)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. For Tdap only: Encephalopathy (e.g., coma, decreased level of consciousness, or prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of Tdap or diphtheria and tetanus toxoids and pertussis (DTP) or diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.	Moderate or severe acute illness with or without fever. GBS within 6 weeks after a previous dose of tetanus toxoid--containing vaccine. History of arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid--containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid--containing vaccine. For Tdap only: Progressive or unstable neurologic disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized.
Varicella, ²	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, or long-term immunosuppressive therapy ⁴ or patients with human immunodeficiency virus (HIV) infection who are severely immunocompromised). Pregnancy.	Recent (≤ 11 months) receipt of antibody-containing blood product (specific interval depends on product). ⁵ Moderate or severe acute illness with or without fever. Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, delay resumption of these antiviral drugs for 14 days after vaccination.
Human papillomavirus (HPV)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.	Moderate or severe acute illness with or without fever. Pregnancy.
Zoster	Severe allergic reaction (e.g., anaphylaxis) to a vaccine component. Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, or long-term immunosuppressive therapy ⁴ or patients with HIV infection who are severely immunocompromised). Pregnancy.	Moderate or severe acute illness with or without fever. Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; if possible, avoid use of these antiviral drugs for 14 days after vaccination.

See table footnotes on page 7.

TABLE. (Continued) Contraindications and precautions to commonly used vaccines in adults^{1,*†}

Vaccine	Contraindications	Precautions
Measles, mumps, rubella (MMR) ²	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component. Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, or long-term immunosuppressive therapy ⁴ or patients with HIV infection who are severely immunocompromised). Pregnancy.	Moderate or severe acute illness with or without fever. Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product). ⁶ History of thrombocytopenia or thrombocytopenic purpura. Need for tuberculin skin testing. ⁷
Pneumococcal polysaccharide (PPSV)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.	Moderate or severe acute illness with or without fever.
Meningococcal, conjugate, (MCV4); meningococcal, polysaccharide (MPSV4)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.	Moderate or severe acute illness with or without fever.
Hepatitis A (HepA)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.	Moderate or severe acute illness with or without fever. Pregnancy.
Hepatitis B (HepB)	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component.	Moderate or severe acute illness with or without fever.

1. Vaccine package inserts and the full ACIP recommendations for these vaccines should be consulted for additional information on vaccine-related contraindications and precautions and for more information on vaccine excipients. Events or conditions listed as precautions should be reviewed carefully. Benefits of and risks for administering a specific vaccine to a person under these circumstances should be considered. If the risk from the vaccine is believed to outweigh the benefit, the vaccine should not be administered. If the benefit of vaccination is believed to outweigh the risk, the vaccine should be administered.

2. LAIV, MMR, and varicella vaccines can be administered on the same day. If not administered on the same day, these live vaccines should be separated by at least 28 days.

3. See CDC. Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2010. MMWR 2010;59(No. RR-8). Available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

4. Substantially immunosuppressive steroid dose is considered to be ≥ 2 weeks of daily receipt of 20 mg or 2 mg/kg body weight of prednisone or equivalent.

5. Vaccine should be deferred for the appropriate interval if replacement immune globulin products are being administered.

6. See CDC. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2011;60(No. RR-2). Available at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>.

7. Measles vaccination might suppress tuberculin reactivity temporarily. Measles-containing vaccine may be administered on the same day as tuberculin skin testing. If testing cannot be performed until after the day of MMR vaccination, the test should be postponed for ≥ 4 weeks after the vaccination. If an urgent need exists to skin test, do so with the understanding that reactivity might be reduced by the vaccine.

* Adapted from CDC. Table 6. Contraindications and precautions to commonly used vaccines. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices. MMWR 2011;60(No. RR-2):40-41 and from Atkinson W, Wolfe S, Hamborsky J, eds. Appendix A. Epidemiology and prevention of vaccine preventable diseases. 12th ed. Washington, DC: Public Health Foundation, 2011. Available at <http://www.cdc.gov/vaccines/pubs/pinkbook/default.htm>.

† Regarding latex allergy: some types of prefilled syringes contain natural rubber latex or dry natural latex rubber. Consult the package insert for any vaccine administered.

More information on vaccine components, contraindications, and precautions also is available from specific vaccine package inserts and ACIP recommendations for specific vaccines, and is summarized in Atkinson W, Wolfe S, Hamborsky J, eds. Epidemiology and prevention of vaccine preventable diseases. 12th ed. Washington, DC: Public Health Foundation, 2011. Available at <http://www.cdc.gov/vaccines/pubs/pinkbook/default.htm>.

Recommended Immunization Schedules for Persons Aged 0 Through 18 Years

UNITED STATES, 2012

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

The Recommended Immunization Schedules for
Persons Aged 0 Through 18 Years are approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/recs/acip)

American Academy of Pediatrics
(<http://www.aap.org>)

American Academy of Family Physicians
(<http://www.aafp.org>)



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹		Hep B	HepB			HepB								Range of recommended ages for all children
Rotavirus ²			RV	RV	RV ²									
Diphtheria, tetanus, pertussis ³			DTaP	DTaP	DTaP		see footnote ³	DTaP					DTaP	
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴			Hib						Range of recommended ages for certain high-risk groups
Pneumococcal ⁵			PCV	PCV	PCV			PCV				PPSV		
Inactivated poliovirus ⁶			IPV	IPV		IPV							IPV	
Influenza ⁷								Influenza (Yearly)						
Measles, mumps, rubella ⁸								MMR		see footnote ⁸			MMR	Range of recommended ages for all children and certain high-risk groups
Varicella ⁹								Varicella		see footnote ⁹			Varicella	
Hepatitis A ¹⁰								Dose 1 ¹⁰				HepA Series		
Meningococcal ¹¹								MCV4 — see footnote ¹¹						

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing $\geq 2,000$ grams, and HepB vaccine plus HBIG for infants weighing $< 2,000$ grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing $\geq 2,000$ grams (no later than age 1 week).

Doses after the birth dose:

- The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
- The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])

- The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.

5. Pneumococcal vaccines. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
 - All children aged 14 through 59 months
 - Children aged 60 through 71 months with underlying medical conditions.
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

7. Influenza vaccines. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf>.
- For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)

- Administer the second (final) dose 6 to 18 months after the first.
- Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf>.
- A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.

11. Meningococcal conjugate vaccines, quadrivalent (MCV4). (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])

- For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
- For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
- For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
- See *MMWR* 2011;60:72–6, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, and *MMWR* 2011;60:1391–2, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf>, for further guidance, including revaccination guidelines.

FIGURE 2: Recommended immunization schedule for persons aged 7 through 18 years—United States, 2012 (for those who fall behind or start late, see the schedule below and the catch-up schedule [Figure 3])

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, diphtheria, pertussis ¹		1 dose (if indicated)	1 dose	1 dose (if indicated)	Range of recommended ages for all children
Human papillomavirus ²		see footnote ²	3 doses	Complete 3-dose series	
Meningococcal ³		See footnote ³	Dose 1	Booster at 16 years old	
Influenza ⁴		Influenza (yearly)			
Pneumococcal ⁵		See footnote ⁵			Range of recommended ages for catch-up immunization
Hepatitis A ⁶		Complete 2-dose series			
Hepatitis B ⁷		Complete 3-dose series			
Inactivated poliovirus ⁸		Complete 3-dose series			Range of recommended ages for certain high-risk groups
Measles, mumps, rubella ⁹		Complete 2-dose series			
Varicella ¹⁰		Complete 2-dose series			

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
 - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
 - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
 - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
 - The vaccine series can be started beginning at age 9 years.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
 - See *MMWR* 2010;59:626–32, available at <http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf>.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).**
 - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
 - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
 - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
 - If the first dose is administered at age 16 years or older, a booster dose is not needed.
 - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
 - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
 - See *MMWR* 2011;60:72–76, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, for further guidelines.
- Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
 - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf>.
 - Administer 1 dose to persons aged 9 years and older.
 - For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
- Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
 - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.
 - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
- Hepatitis A (HepA) vaccine.**
 - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf>.
 - Administer 2 doses at least 6 months apart to unvaccinated persons.
- Hepatitis B (HepB) vaccine.**
 - Administer the 3-dose series to those not previously vaccinated.
 - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
 - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered at least 6 months after the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
 - IPV is not routinely recommended for U.S. residents aged 18 years or older.
- Measles, mumps, and rubella (MMR) vaccine.**
 - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
- Varicella (VAR) vaccine.**
 - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at <http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf>), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

FIGURE 3. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States • 2012

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with the accompanying childhood and adolescent immunization schedules (Figures 1 and 2) and their respective footnotes.**

Persons aged 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to dose 2	Dose 2 to dose 3	Dose 3 to dose 4	Dose 4 to dose 5
Hepatitis B	Birth	4 weeks	8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks		
Rotavirus ¹	6 weeks	4 weeks	4 weeks ¹		
Diphtheria, tetanus, pertussis ²	6 weeks	4 weeks	4 weeks	6 months	6 months ²
<i>Haemophilus influenzae</i> type b ³	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age 15 months or older	4 weeks ³ if current age is younger than 12 months 8 weeks (as final dose) ³ if current age is 12 months or older and first dose administered at younger than age 12 months and second dose administered at younger than 15 months No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months	
Pneumococcal ⁴	6 weeks	4 weeks if first dose administered at younger than age 12 months 8 weeks (as final dose for healthy children) if first dose administered at age 12 months or older or current age 24 through 59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose for healthy children) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age	
Inactivated poliovirus ⁵	6 weeks	4 weeks	4 weeks	6 months ⁵ minimum age 4 years for final dose	
Meningococcal ⁶	9 months	8 weeks ⁶			
Measles, mumps, rubella ⁷	12 months	4 weeks			
Varicella ⁸	12 months	3 months			
Hepatitis A	12 months	6 months			
Persons aged 7 through 18 years					
Tetanus, diphtheria/ tetanus, diphtheria, pertussis ⁹	7 years ⁹	4 weeks	4 weeks if first dose administered at younger than age 12 months 6 months if first dose administered at 12 months or older	6 months if first dose administered at younger than age 12 months	
Human papillomavirus ¹⁰	9 years	Routine dosing intervals are recommended ¹⁰			
Hepatitis A	12 months	6 months			
Hepatitis B	Birth	4 weeks	8 weeks (and at least 16 weeks after first dose)		
Inactivated poliovirus ⁵	6 weeks	4 weeks	4 weeks ⁵	6 months ⁵	
Meningococcal ⁶	9 months	8 weeks ⁶			
Measles, mumps, rubella ⁷	12 months	4 weeks			
Varicella ⁸	12 months	3 months if person is younger than age 13 years 4 weeks if person is aged 13 years or older			

1. Rotavirus (RV) vaccines (RV-1 [Rotarix] and RV-5 [Rota Teq]).

- The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- If RV-1 was administered for the first and second doses, a third dose is not indicated.

2. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.

- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.

3. *Haemophilus influenzae* type b (Hib) conjugate vaccine.

- Hib vaccine should be considered for unvaccinated persons aged 5 years or older who have sickle cell disease, leukemia, human immunodeficiency virus (HIV) infection, or anatomic/functional asplenia.
- If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax) and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months and at least 8 weeks after the second dose.
- If the first dose was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months.

4. Pneumococcal vaccines. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- For children aged 24 through 71 months with underlying medical conditions, administer 1 dose of PCV if 3 doses of PCV were received previously, or administer 2 doses of PCV at least 8 weeks apart if fewer than 3 doses of PCV were received previously.
- A single dose of PCV may be administered to certain children aged 6 through 18 years with underlying medical conditions. See age-specific schedules for details.
- Administer PPSV to children aged 2 years or older with certain underlying medical conditions. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.

5. Inactivated poliovirus vaccine (IPV).

- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak).
- IPV is not routinely recommended for U.S. residents aged 18 years or older.

6. Meningococcal conjugate vaccines, quadrivalent (MCV4). (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])

- See Figure 1 ("Recommended immunization schedule for persons aged 0 through 6 years") and Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years") for further guidance.

7. Measles, mumps, and rubella (MMR) vaccine.

- Administer the second dose routinely at age 4 through 6 years.

8. Varicella (VAR) vaccine.

- Administer the second dose routinely at age 4 through 6 years. If the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

9. Tetanus and diphtheria toxoids (Td) and tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccines.

- For children aged 7 through 10 years who are not fully immunized with the childhood DTaP vaccine series, Tdap vaccine should be substituted for a single dose of Td vaccine in the catch-up series; if additional doses are needed, use Td vaccine. For these children, an adolescent Tdap vaccine dose should not be given.
- An inadvertent dose of DTaP vaccine administered to children aged 7 through 10 years can count as part of the catch-up series. This dose can count as the adolescent Tdap dose, or the child can later receive a Tdap booster dose at age 11–12 years.

10. Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).

- Administer the vaccine series to females (either HPV2 or HPV4) and males (HPV4) at age 13 through 18 years if patient is not previously vaccinated.
- Use recommended routine dosing intervals for vaccine series catch-up; see Figure 2 ("Recommended immunization schedule for persons aged 7 through 18 years").

Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967). Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (<http://www.cdc.gov/vaccines>) or by telephone (800-CDC-INFO [800-232-4636]).